MASTER AGREEMENT REGARDING THE TRI-LATERAL RELATIONSHIP AND BUDGET MANAGEMENT PROCESS FOR STRATEGIC PHYSICIAN AGREEMENTS

MADE EFFECTIVE APRIL 1, 2003

AMONGST:

HER MAJESTY THE QUEEN
IN RIGHT OF ALBERTA
As represented by the
MINISTER OF HEALTH AND WELLNESS
(the "Department")

And

THE ALBERTA MEDICAL ASSOCIATION
(C.M.A. ALBERTA DIVISION)
(the "Association")

And

THOSE REGIONAL HEALTH AUTHORITIES IDENTIFIED IN THE ATTACHED SCHEDULE "A"
(the "Authorities")

RECITALS:

A. The Department and the Association have previously entered into the agreements identified in the attached Schedule "B" (the "Prior Agreements") some of which expired effective April 1, 2003 and the balance of which will expire on the execution of this Agreement;

B. The Department, the Association and the Authorities have been actively involved in "interest based" discussions and negotiations since November, 2002;

C. The discussions and negotiations have culminated in an "agreement in principle" reached on June 26, 2003, which agreement in principle is conditional upon the drafting of formal documents and the successful completion of ratification processes by each of the Department, the Association and the Authorities;

D. The parties have decided to enter into this master agreement (the "Master Agreement") which is intended to describe the creation of a new tri-lateral relationship among them (the "Relationship"); and

E. The Relationship is based upon trust, respect, confidence, communication, collaboration and cooperation.

THEREFORE the Department, the Association and each of the signatory Authorities, promise and agree each with the other as follows:

ARTICLE 1
TERM

1.1 The term of this Master Agreement and any initial Strategic Physician Agreement entered into hereunder shall commence on the Effective Date and shall, notwithstanding any notice to reopen negotiations served pursuant to paragraph 11.2, remain in full force and effect only until twelve (12) o'clock midnight March 31, 2011.

ARTICLE 2
ACKNOWLEDGEMENTS

2.1 The Parties acknowledge and confirm that:

(a) The Premier's Advisory Council on Health (the Mazankowski Report) and other reports and studies identified the need for improvement in the health care delivery system in Alberta and in the whole of Canada. These reports and studies contain many recommendations some of which have been accepted by the Parties and some of which are in the process of being implemented;

(b) Alberta's regional health authority system has been restructured effective April 1, 2003 and the number of Authorities reduced from 17 to 9;

(c) The restructured regional health authority system:

(i) has been challenged by the Minister to be more collaborative and innovative when dealing with the numerous challenges affecting the delivery of quality health care services to Albertans, and

(ii) is required by the Minister to be more accountable, including the signing of multi-year performance agreements;

(d) The Parties have a shared obligation and responsibility to ensure that quality health care services are delivered to Albertans through a delivery system which is accessible, predictable, integrated, sustainable, adaptable, accountable, efficient and effective (the Health Care Delivery System);

(e) Numerous matters previously discussed and negotiated between the Department and the Association affect the Health Care Delivery System. The Minister decided that it is essential that the Authorities be involved in these discussions and negotiations both now and in the future;

(f) The Minister offered an expanded and an enhanced role and relationship to the Association regarding how to improve the Health Care Delivery System;

(g) The Association and the Authorities have accepted their new role and the associated challenges and responsibilities;

(h) In order for the Relationship to be successful, it must have stability, in terms of the length of time that the Relationship will be in place, and predictability, in terms of general and specific funding and in terms of how budgeted funding is managed;

(i) The Parties acknowledge and agree that key health care improvement strategies like the Primary Care Initiative, the Physician Office System Program and the Electronic Health Record are significant ways to successfully improve the Health Care Delivery System for the benefit of all Albertans; and

(j) It is the collective desire of the Parties to work together and with other health care service providers in a collaborative and cooperative way to improve the Health Care Delivery System and to provide quality health care services to Albertans.

2.2 The Parties acknowledge and agree that the amount of the Physician Services Budget includes, without limitation, amounts paid by the Department in respect of:

(a) Physician charges for Insured Services provided by Physicians to Residents in conjunction with other health providers or otherwise permitted pursuant to the Schedule or an Alternate Relationship Plan;

(b) Insured Services provided to non eligible persons in good faith; and

(c) Insured Services provided to Residents by physicians licensed to practise in the Province of Saskatchewan and practising in Lloydminster.

2.3 The Parties further acknowledge that some Insured Services are paid through Authority or other budgets and are not included in the amount of Master Physician Budgets set out in Schedule "C". Such amounts are not to be included in or accounted for through the Master Physician Budgets, or any Element thereof, except and to the extent that the Master Committee reaches Consensus.

2.4 The Department shall provide the Association and the Authorities with not less than ninety (90) days prior written notice (in this paragraph the "Notice") of any intention to De-Insure an Insured Service or add to the list of Insured Services.

(a) Within forty five (45) days of receipt of a Notice, the Physician Services Committee shall consider the Notice and the said committee:

(i) May make a report or recommendation to the Secretariat as to the merits of the proposed addition to the list of Insured Services or De-Insurance as the case might be; and

(ii) Shall make a report or recommendation to the Secretariat respecting the direct financial impact, if any, that the proposed addition to the list of Insured Services or De-Insurance will have on the Physician Services Budget.

(b) Within twenty (20) days of receipt of the said report or recommendation, the Secretariat shall consider the matter and forward a report or recommendation to the Master Committee for consideration, with such additional information, comments or recommendations, if any, that the Secretariat considers appropriate.

(c) The Master Committee shall, forthwith, consider the material received and forward a report or recommendation to the Minister. The Minister shall consider, but shall not be obliged to act on, the report or recommendations made. The Minister shall have the unfettered discretion to De-Insure an Insured Service or add to the list of Insured Services.

(d) The amount of any adjustment to the Physician Services Budget arising out of the Minister's decision pursuant to paragraph 2.4(c) shall be a Consensus decision of the Master Committee, failing which the matter may be referred to arbitration in accordance with the provisions of Article 10.

ARTICLE 3
RELATIONSHIP AND BUDGET MANAGEMENT COMMITTEES

3.1 The Parties hereby constitute the following committees to manage, oversee and provide general guidance to the Relationship and budget management processes, namely:

(a) The Tri-lateral Relationship and Budget Management Process Master Committee (the "Master Committee") consisting of the Deputy Minister of the Department, the Chief Executive Officer of the Association, and a Chief Executive Officer of an Authority chosen, from time to time, by the Council of CEOs of the Authorities (or anyone duly authorized to act on behalf of any one or more of the above mentioned individuals during an unavoidable and temporary absence); and

(b) The Tri-lateral Relationship and Budget Management Process Secretariat (the "Secretariat") consisting of up to three (3) appointees of each of the Department, the Association and the Authorities. The Department's appointees shall include the Assistant Deputy Minister responsible for overseeing this Master Agreement. The appointees of the Authorities shall, absent Consensus to the contrary, initially include one person appointed by each of Capital Health and the Calgary Health Region and one other person chosen by the Council of CEOs of the Authorities. The Authorities' appointees shall be of a senior level and may include a chief executive

officer, a chief financial officer or a chief medical officer. The appointees of the Association shall be of an equivalent seniority within the Association and may include Physicians.

3.2 The Master Committee shall have general responsibility for the management of the Relationship and, without limitation, shall on Consensus and from time to time, have the sole authority, subject always to the provisions hereof, to:

(a) Improve the Relationship and the budget management review and adjustment process set out herein and to effect such improvement by amending this Master Agreement or a Strategic Physician Agreement;

(b) Enter into a new Strategic Physician Agreement;

(c) Resolve any matter, issue or dispute assumed by it or forwarded to it by the Secretariat or in respect of which the Secretariat is unable to reach a Consensus, except as otherwise herein expressly provided;

(d) Approve by Consensus any adjustment contemplated by sub paragraphs 8.10(b), (c) or (d); or

(e) Amend, vary, change, adjust, reallocate or redistribute any Element or sub Element of the Master Physician Budget.

3.3 The Secretariat shall report to the Master Committee and shall oversee and generally manage the operations of the Strategic Physician Agreements and all SPA Committees.

3.4 The Secretariat shall, at such time and in such manner as the Master Committee might from time to time direct, prepare recommendations for consideration of the Master Committee relating to adjustments, if any, required or recommended in accordance with the budget management process set out in Article 8 hereof.

3.5 Decisions or recommendations of the Master Committee or the Secretariat shall be by Consensus.

3.6 If the Secretariat is unable to reach Consensus on any matter, issue or dispute properly to be considered by it, then that matter, issue or dispute shall be forwarded to the Master Committee for consideration; provided always that any member of the Secretariat may, at any time and from time to time, require that a matter, issue or dispute presently before the Secretariat be referred to the Master Committee for

consideration without the requirement that such matter, issue or dispute be finally considered by the Secretariat.

3.7 A Consensus decision by the Master Committee shall be final and binding upon the Parties. If the Master Committee is unable to reach Consensus such matter, issue or dispute shall, subject to the provisions of paragraph 10.2, be referred to binding arbitration in accordance with the dispute resolution process set out in Article 10 hereof.

ARTICLE 4
STRATEGIC PHYSICIAN AGREEMENT COMMITTEES

4.1 The Parties hereby constitute the following SPA Committees to oversee the general operation and management of the Strategic Physician Agreements formed in accordance with paragraph 5.1 below, namely:

(a) Physician Services Committee;

(b) Physician Office System Program Committee;

(c) Primary Care Initiative Committee;

(d) Physician On Call Programs Committee; and

(e) Any other committee that the Master Committee might form from time to time to oversee the management of a Strategic Physician Agreement.

4.2 Each SPA Committee shall have up to nine (9) members, up to three (3) of whom shall be appointed by each one of the Parties.

4.3 Each SPA Committee shall forthwith following the signing of this Master Agreement prepare a document (the "Mandate") recommending its terms of reference, roles, responsibilities and the time frame for decision or recommendation as the case might be. The Mandate shall be forwarded at a time and in a form satisfactory to the Secretariat. No Mandate or amendment, variation, expansion or other change to a Mandate shall be effective until approved by the Secretariat or the Master Committee as the case might be.

4.4 Each SPA Committee shall only have the power and authority to make binding decisions as set out in the Strategic Physician Agreement for which it is responsible or as set out in its Mandate. In the event of a conflict or inconsistency between the terms of

the Strategic Physician Agreement and the SPA Committee's Mandate the former shall prevail.

4.5 Each SPA Committee may, except as otherwise directed by the Secretariat, create and control its own processes but shall keep minutes of all of its meetings and shall provide copies of same to the Secretariat within fifteen (15) days following any meeting.

4.6 Each SPA Committee may refer any matter, issue or dispute for which it is responsible to a subcommittee formed by it, which subcommittee need not be composed of members of the SPA Committee. Any subcommittee so formed shall not have the ability to make binding decisions but shall instead report back to or make recommendations for the consideration of the SPA Committee.

4.7 A SPA Committee shall provide any information pertaining to matters related to its operations or the Strategic Physician Agreement or budget element being managed by it, at a time and in a form, requested by the Secretariat.

4.8 Decisions or recommendations of a SPA Committee shall be by Consensus. In the event that Consensus cannot be reached on any matter, issue or dispute properly to be considered by it that matter, issue or dispute shall be forwarded to the Secretariat for consideration; provided always that any member of the SPA Committee shall be permitted, at any time and from time to time, to require that a matter, issue or dispute presently before it be referred to the Secretariat for consideration without the requirement that such matter, issue or dispute be finally considered by the SPA Committee.

4.9 Each SPA Committee shall, where any matter, issue or dispute before it impacts or has the potential to impact the operation of another Strategic Physician Agreement, consult with the Secretariat and the SPA Committee impacted or potentially impacted by that matter, issue or dispute (and as otherwise directed by the Secretariat), prior to making any decision or recommendation in respect of that matter, issue or dispute.

4.10 The Department shall provide administrative support for the Master Committee, the Secretariat and all SPA Committees and sub-committees, including, without limitation, secretarial support, preparation and distribution of minutes, agendas and the provision of meeting facilities. Each of the Parties to this Master Agreement shall bear the

costs for the members that it appoints to the Master Committee, the Secretariat or a SPA Committee, including, without limitation, costs relating to preparation, travel or attendance.

ARTICLE 5
STRATEGIC PHYSICIAN AGREEMENTS

5.1 The Parties agree that the initial Strategic Physician Agreements shall be entered into under this Master Agreement, namely:

(a) Physician Services Agreement;

(b) Physician Office System Program Agreement;

(c) Primary Care Initiative Agreement;

(d) Physician On Call Programs Agreement; and

(e) Such other Strategic Physician Agreements as the Master Committee, from time to time, determines should be managed by the Relationship and budget management process set out in this Master Agreement.

5.2 The Strategic Physician Agreements identified in subparagraphs 5.1(a) through (d) above shall be in the form set out in Schedules "E" to "H" respectively attached hereto and shall, without more, become effective upon the signing of this Master Agreement by the Parties and without the need for further execution or formality. Any Strategic Physician Agreement subsequently entered into pursuant to subparagraph 5.1(e) shall become effective when signed by each of the members of the Master Committee on behalf of the Parties that those individuals respectively represent.

5.3 The Parties acknowledge that the scope of this Master Agreement may be expanded to encompass other budgets respecting Physicians and other Strategic Physician Agreements, if and when the Master Committee reaches Consensus. The Master Committee, through the Secretariat, will initially, without limitation, forthwith start to review the desirability of expanding the scope of this Master Agreement to encompass any of the following:

(a) Legacy APPs;

(b) Acute Care Coverage Programs;

(c) Laboratory Physician services;

(d) Diagnostic Imaging Physician services currently provided through the Authorities;

(e) Cancer treatment Physician services currently provided through the Alberta Cancer Board;

(f) Physicians, funded by the Department, who are in the process of preparing for certification by either the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada;

(g) Voluntary organizations that provide services under contract to an Authority;

(h) Interpretation Fees; or

(i) Academic Medicine.

ARTICLE 6
REPORTING OF PHYSICIAN AGREEMENTS

6.1 The parties acknowledge the complexity of the Physician/Authority arrangements and the need for some local flexibility when making such arrangements. Accordingly, when implementing paragraphs 6.2 and 6.3 the Master Committee shall ensure that all reporting mechanisms are reasonable and do not create undue administrative burden for Physicians or Authorities.

6.2 Each Authority shall provide the Master Committee with not less than fifteen (15) days (or such other time as the Master Committee might prescribe from time to time) prior written notice (in this Article, the "Notice") in form and substance satisfactory to the Master Committee of the Authority's intention to enter into a Physician Agreement:

(a) Any proposed Alternate Relationship Plan shall be forwarded to the Physician Services Committee to be dealt with pursuant to the Physician Services Agreement;

(b) Any proposed Physician Agreement related to a proposed Alternate Relationship Plan shall be forwarded to the Master Committee together with such other information or documents as the Master Committee may request from time to time;

(c) With respect to any Physician Agreement by which the Physician, for or in respect to the provision of Insured Services, is to receive only fee for service compensation or where it is intended that the Physician will receive no

more than the Provincial Payment Rate and provided always that the payment for any administrative or other service to be performed by the Physician can reasonably be considered as intended to supplement the Physician's compensation for the provision of Insured Services then the Master Committee may provide comments to the Authority concerning the Physician Agreement. The Master Committee shall not have the authority to either approve or require amendments to the Physician Agreement. Comments, if any, shall be provided within five (5) days of receipt of the Notice failing which the Authority may finalize the said agreement;

(d) With respect to any Physician Agreement or Alternate Relationship Plan by which an Authority requests a supplement from the Insured Services Element no such supplement shall occur nor shall such agreement be finalized without the Consensus of the Master Committee. Notice of Consensus, if any, shall be provided within fifteen (15) days, or such greater or lesser time as the Master Committee might from time to time direct, of receipt of the Notice;

(e) With respect to any Physician Agreement by which an Authority, from the Authority's own budget or resources, intends to supplement, guarantee or otherwise enhance the compensation to be received by the Physician for or in respect to the provision of such Insured Services the Master Committee shall have a right of approval respecting such Physician Agreement;

(f) In the event that the Master Committee cannot reach Consensus respecting an intended Physician Agreement considered pursuant to sub paragraph 6.2(e) above within fifteen (15) days of receipt of the Notice, then the Deputy Minister of the Department shall be the sole and final arbitrator and decision maker as to whether or not the Physician Agreement may be finalized, whether as proposed or amended; and

(g) Any member of the Master Committee may require that a Physician Agreement received under the provisions of sub paragraph 6.2(c) be considered under the provisions of sub paragraph 6.2(e).

6.3 The Authorities shall, forthwith after this Master Agreement is signed by each of the Parties, provide to the Master Committee a listing of each Physician Agreement existing as at the Effective Date. The Master Committee shall have no ability to approve or disapprove either the listing or the said agreements, which are provided for information only. The disclosure contemplated in this paragraph shall occur to the greatest extent permitted by law and each Authority shall use it's best efforts to obtain the consent to so disclose from every Physician or body corporate who might be a party to or interested in such Physician Agreement. The Authorities shall also use their best efforts to obtain any consent required to disclose similar agreements entered into between service providers operating under contract with the Authority and Physicians.

6.4 The Association and the Authorities may disclose any Physician Agreement received by them under the provisions of either paragraph 6.2 or 6.3 above on a confidential basis to their respective senior officers on a need to know basis and their respective Boards of Directors and the Department may disclose such information on a confidential and need to know basis within the ministry.

ARTICLE 7
RECOGNITION

7.1 The Parties shall, in accordance with the provisions of this Master Agreement, recognize the rights assigned to each which includes a recognition of the right of the Association to be the sole and exclusive representative of Physicians in Alberta with respect to all matters contained within this Master Agreement and all Strategic Physician Agreements created hereunder and all agreements, budgets, programs or services contemplated therein, including any expanded scope agreed upon under paragraph 5.3 hereof.

7.2 The Parties shall respect the right of a Physician to have, at that Physician's request, the Association represent the interests of that Physician in any negotiations with the Authority respecting all matters contained within this Master Agreement and all Strategic Physician Agreements created hereunder and all agreements, budgets, programs or services contemplated therein, including any expanded scope agreed upon under paragraph 5.3 hereof.

ARTICLE 8
MANAGEMENT AND ADJUSTMENT OF THE MASTER PHYSICIAN BUDGET

8.1 The Parties acknowledge and agree that strong and effective budget management, review and adjustment is essential for the sustainability of the Health Care Delivery System.

8.2 The Master Committee will oversee the management, review and adjustment of the Master Physician Budget over the term of this Master Agreement.

8.3 The Parties agree that, subject to adjustment, if any, as set out in this Article 8, the Master Physician Budgets will, at the start of each Fiscal Year, initially be as set out in Schedule "C" appended hereto.

8.4 The Parties acknowledge that the Master Physician Budgets set out in Schedule "C" provide, subject always to the budget management and adjustment processes set out in this Article 8, for the following increases to the Insured Services Element:

(a) 2.7% effective October 1, 2003;

(b) 2.9% effective October 1, 2004; and

(c) 3.5% effective October 1, 2005.

8.5 The Parties further acknowledge that the Insured Services Element set out in Schedule "C" includes allowances for volume increases based on growth in population of:

(a) 1.95% for the 2003/04 Fiscal Year;

(b) 1.90% for the 2004/05 Fiscal Year; and

(c) 2.21% for the 2005/06 Fiscal Year.

8.6 The Parties further acknowledge that the budget management process contemplated by this Master Agreement will require the projection of expenditures by using a variety of forecasting models and economic indicators including, initially, the existing forecasting models. Such projections will be based on the latest available information at the time of the calculation. The acceptance and relevance of the forecasting models and economic indicators shall be determined by Consensus by the Physician Services Committee, the Secretariat or the Master Committee as the case might be. If the Master Committee is unable to reach Consensus the matter may be referred to dispute resolution in accordance with Article 10 hereof.

8.7 The Secretariat will throughout the term of this Master Agreement monitor expenditures in the Master Physician Budget and provide the Master Committee with an analysis of Actual Expenditures, as compared to budget, for each Element or sub Element of the Master Physician Budget at such time and in such manner as the Master Committee might from time to time direct.

8.8 The Secretariat shall also maintain such other records and reports as the Master Committee might from time to time direct, including a record by Fiscal Year and cumulatively from the Effective Date of any Over Expenditure, adjustment (actual or projected) or surplus in or to each Element comprising the Master Physician Budget.

8.9 In the event that any Element of the Master Physician Budget is Over Expended in any Fiscal Year the Master Committee may, with Consensus, reduce or eliminate any such Over Expenditure by reallocating all or any portion of a surplus (excluding the Benefit Surplus) existing in any one or more Elements of the Master Physician Budget that the Master Committee determines appropriate; provided always that the adjustment contemplated in paragraph 8.18 shall, absent Consensus of the Master Committee to the contrary, occur automatically and the Master Committee may not permanently reallocate money from the Primary Care Initiative Budget Element to any other Element of the Master Physician Budget.

8.10 If the Master Committee is unable to reach Consensus under paragraph 8.9 above or if an Over Expenditure remains in the Insured Services Element after the Master Committee has made the adjustments upon which Consensus has been reached and the Over Expenditure is due to the happening of one or more of the following, then the Master Committee, having reviewed the report or recommendations of the Secretariat, shall report to the Minister that the Department is obliged to decrease or eliminate the Over Expenditure by an amount equal to the aggregate of:

(a) The amount resulting from multiplying the base of the Insured Services Element for the Fiscal Year to which the adjustment is to relate by the percentage increase in population in Alberta that exceeds the budgeted percentage volume increases based on population growth set out in paragraph 8.5 above. Population growth shall be based upon Alberta Finance (Statistics Branch) calculations as of April 1st in each Fiscal Year respecting the population in Alberta consistently applied and such increases shall be applied to the Insured Services Element as of April 1 in each Fiscal Year;

(b) An amount equal to the net economic impact on the Insured Services Element resulting from net increases, after the Effective Date, in the number of Physicians actually recruited and practising to meet identified Provincial needs as set out in those:

(i) existing Physician recruitment plans identified in Schedule "I" annexed hereto;

(ii) written Physician recruitment plans (or other similar plans) specifically agreed to in writing by the Master Committee after the Effective Date; and

(iii) ministerial approvals after the Effective Date of communities in Alberta having an emergency need and resulting in increases after the Effective Date in the number of Physicians authorized to practice in Alberta under Part 5 of the Special Register, established under the provisions of the Medical Professions Act, and actually practicing in such communities;

(c) Consensus supplements, if any, from the Insured Services Element approved pursuant to paragraph 6.2(d) hereof; and

(d) Adjustments described in sub paragraphs (a), (b) or (c) above that were not made because there was no Over Expenditure or which were not fully utilized by the Over Expenditure but which subsequently contribute directly to a current Over Expenditure;

provided always that no adjustment under this paragraph shall be greater than the amount of the Over Expenditure or remaining Over Expenditure as the case might be.

8.11 In addition to the adjustments set out in paragraph 8.10 above, the Secretariat may report or recommend to the Master Committee that the Over Expenditure be further reduced or an Element of the Master Physician Budget be adjusted upward to reflect other factors impacting the said Element such as:

(a) Changes in access standards that result in changes in service delivery, including, without limitation, ninety (90) day access or diagnostic imaging standards;

(b) The impact of fee stabilization initiatives to support Physician practices where health system restructuring has required a change in service delivery;

(c) Utilization growth due to unforeseen situations such as West Nile Virus, SARS or BSE;

(d) the addition of new items to the Schedule; other than new items arising out of a decision of the Minister to add to the list of Insured Services in accordance with the provisions of paragraph 2.4(c) hereof;

(e) Higher than anticipated Physician desire to participate in primary care initiatives or the Physician Office System Program;

(f) Adjustments to the Physician Services Budget in respect to the net economic impact on the Insured Services Element resulting from net

increases, after the Effective Date, in the number of Physicians actually practising in Alberta; or

(g) Any other factor considered by the Secretariat to be relevant to the Master Physician Budget; and

on receipt of the Secretariat's report or recommendation the Master Committee shall make a report or recommendation to the Minister regarding further reduction or elimination of the Over Expenditure or upward adjustment to any Element of the Master Physician Budget as the case might be.

8.12 The Minister shall have the unfettered discretion upon receiving the report or recommendation to:

(a) Agree or disagree with same; and

(b) Direct the Department to further reduce any Over Expenditure or make any adjustment to any Element of the Master Physician Budget in response to any report or recommendation made by the Master Committee pursuant to paragraph 8.11 hereof.

8.13 For greater clarity the adjustments contemplated under paragraphs 8.9, 8.10 and 8.11 are intended to reflect the Parties' agreement that the factors set out in subparagraphs 8.10(a), (b) and (c) are considered to be matters beyond the control of Physicians and to balance two different but equal interests of the Parties, namely:

(a) That Physicians should not be financially responsible for an item, event or matter beyond the collective control of Physicians; and

(b) That the Department should not be required to add monies to the Insured Services Element except in the event of an Over Expenditure which arises directly from an item, event or matter that is beyond the collective control of Physicians.

Nothing in this paragraph is intended, or shall be interpreted, as impacting, limiting, or in any way restricting the Minister's unfettered discretion pursuant to paragraph 8.12 hereof.

8.14 In the event that an Over Expenditure remains in the Insured Services Element following the adjustments, if any, referred to in the sub paragraphs 8.9, 8.10 or 8.11 as

the case might be, then the following will occur, in order of priority, to ensure that the Over Expenditure is eliminated during the second Fiscal Year immediately following the Fiscal Year in which the Over Expenditure arose or any such longer or shorter period of time as the Master Committee may determine:

(a) The increase to the Insured Services Element scheduled to occur on October 1 of the Fiscal Year in which the adjustment is to occur and set out in paragraph 8.4 above or to be negotiated under the provisions of reopening this Agreement will be reduced, but only to the minimum extent required, to eliminate the adjusted Over Expenditure for the Fiscal Year in question; and

(b) The fees paid to Physicians under the Schedule and the Provincial Payment Rate paid to Physicians under an Alternate Relationship Plan will be reduced, but only to the minimum extent required, to eliminate the adjusted Over Expenditure for the Fiscal Year in question.

8.15 The adjustment referred to in paragraph 8.14 shall occur on October 1 of the second Fiscal Year immediately following the Fiscal Year in which the Over Expenditure occurred or such other date as the Master Committee might determine on Consensus.

8.16 A dispute arising out of the provisions of paragraph 8.6 shall not delay the adjustment, if any, of the fee increases or reduction of fees as contemplated in paragraph 8.14 above.

8.17 Any referral to arbitration respecting the adjustment referred to in paragraph 8.14 shall be initiated no later than January 31 in the Fiscal Year in which the adjustment would otherwise occur. Any such issue, matter or dispute not submitted by the said date shall in all events become non-arbitrable.

8.18 The Benefit Element shall be increased effective March 31 in each Fiscal Year by an amount equal to the aggregate of:

(a) The costs to the Benefit Element of increased Physician access to the Continuing Medical Education and Medical Liability Reimbursement Program components of the Benefit Plans; and

(b) The increases occurring after the Effective Date, if any, in payments to Eligible Physicians arising directly as a result of increased expenditures under the Medical Liability Reimbursement Program directly arising from premium increases imposed by the Canadian Medical Protective Association;

minus the amount of any surplus, in excess of the Benefit Surplus, accrued from time to time and arising from the operation of the Benefit Plans after the Effective Date or the date of any prior adjustment made pursuant to this paragraph as the case might be and the amount of the base of the Benefit Element for each Fiscal Year remaining until this Master Agreement is next reopened shall be increased by the aggregate of the amount determined under sub paragraphs (a) and (b) above without reduction by the amount of any surplus, in excess of the Benefit Surplus, accrued from time to time and applied to the corresponding increase for the preceding Fiscal Year.

8.19 The Parties specifically acknowledge and agree that the budget management process set out in this Article and the Department's ability to take the steps contemplated in paragraph 8.14 hereof shall not be terminated or otherwise impacted by the reopening of negotiations under Article 11.

ARTICLE 9
SPECIALIST CARE INITIATIVES

9.1 The Parties have agreed to a number of initiatives to promote and enhance specialist care. These initiatives appear in this Master Agreement and the Strategic Physician Agreements. The Parties recognize that to ensure that these separate initiatives are used to best effect, they must be viewed in a comprehensive and co-ordinated fashion. The Master Committee is responsible for ensuring that these various initiatives are integrated to achieve the maximum benefit.

9.2 The initiatives referred to in paragraph 9.1 above include the following:

(a) Insured Services Element

(i) the Master Agreement provides for the general adjustment of fees paid to Physicians through the Schedule and Provincial Payment Rates as set out in paragraph 8.4 thereof, a portion of which increases will accrue to the benefit of specialist Physicians;

(ii) the Insured Services Element also provides funding for other changes to support primary care and specialist care; and

(iii) the market adjustments contemplated in paragraph 5.6 of the Physician Services Agreement.

(b) Surcharges and Premiums

(i) the Master Physician Budgets for Fiscal 2004/05 and 2005/06 allocates the aggregate amount of $10,000,000 to be used for the revision of surcharge and premium rules and rates, a portion of which will accrue to the benefit of specialist Physicians.

(c) Specialist Linkages to the Primary Care Initiative

(i) the Primary Care Initiative Agreement provides for $10,000,000 of the Primary Care Initiative Budget to be directed towards recognizing the value added services in specialist linkages to the Primary Care Initiative; and

(ii) the Association's Practice Management Program as referenced in paragraph 11.1(b)(iii) of the Primary Care Initiative Agreement.

(d) Physician On Call Programs

(i) the Physician On Call Programs Agreement provides continued and additional funding to the Specialist On Call Program to:

A. add new programs eligible for specialist on call;

B. adjust the payment rate for specialist on call programs to make them consistent with rural on call program rates; and

C. adjust the payment rates for on call programs within the ability of the Physician On Call Programs Budget.

(e) Budget Management and Adjustment Process

(i) the budget management and adjustment process described in Article 8 of the Master Agreement provides for the adjustment of the Insured Services Element for the addition of Physicians to the Province through written recruitment plans agreed to in writing by the Master Committee pursuant to paragraph 8.10(b) thereof.

(f) Physician Office System Program

(i) expanded eligibility for funding under the Physician Office System Program in accordance with paragraph 4.8 of the Physician Office System Program Agreement.

ARTICLE 10
DISPUTE RESOLUTION

10.1 Subject always to the provisions of paragraph 10.2 below should the Master Committee be unable to reach Consensus relating to:

(a) Any matter, issue or dispute to be decided by it under this Master Agreement;

(b) The interpretation, application or operation or contravention or alleged contravention of this Master Agreement;

(c) Whether any of the differences set out in sub paragraphs (a) or (b) above can be the subject of arbitration; or

(d) The amount of any Element of the Master Physician Budget arising out of reopened negotiations in 2006 or 2008;

then any or all of the aforesaid differences (hereinafter in this Article an "Issue") shall be referred to arbitration in accordance with the provisions of this Article.

10.2 Notwithstanding anything to the contrary in this Master Agreement, a Strategic Physician Agreement or a Mandate, the following items are not subject to dispute resolution or arbitrable under this Master Agreement:

(a) The inability of the Master Committee to reach Consensus regarding any item that could reasonably be considered as expanding, adding to or materially altering the Relationship, including, without limitation:

  (i) an extended term of this Master Agreement or any Strategic Physician Agreement; or

  (ii) whether a new Strategic Physician Agreement should be entered into;

  (iii) whether this Master Agreement or any Strategic Physician Agreement should be amended or altered in any of their respective provisions;

(b) The inability of the Master Committee to reach Consensus regarding:

  (i) a request for a supplement made pursuant to paragraph 6.2(d);

  (ii) approval of a physician recruitment plan referred to in paragraph 8.10(b);

  (iii) any reallocation of the Master Physician Budget pursuant to paragraph 8.9;

(iv) the date on which an adjustment is to occur pursuant to paragraph 8.14; or

(v) a matter or issue, other than a financial matter of any kind, referred to in a notice to reopen negotiations served pursuant to paragraph 11.1;

(c) The inability of the Parties to reach agreement respecting a non financial matter referred to above and in respect of which Concensus to negotiate was reached, unless the Master Committee has specifically determined that such matter should be referred to dispute resolution in the absence of agreement;

(d) A decision by the Deputy Minister of the Department made pursuant to paragraph 6.2(f) hereof;

(e) The elimination of an Over Expenditure pursuant to paragraph 8.14 hereof;

(f) The adjustments, if any, contemplated by paragraph 8.10(a); or

(g) The exercise of discretion by the Minister respecting:

(i) any decision to add an Insured Service to the Schedule or to De-Insure an Insured Service pursuant to paragraph 2.4(c); or

(h) any discretionary adjustment contemplated under paragraph 8.11.

10.3 All submissions to arbitration shall be in writing and contain a list of the Issues permitted to be arbitrated or claimed to be arbitrable and shall be forwarded to each of the other Parties.

10.4 Within seven (7) business days of receipt of a submission to arbitration the responding Party or Parties shall prepare and deliver a written response.

10.5 Within seven (7) business days of the earlier of the due date and receipt of a response to a submission to arbitration the Master Committee shall meet to determine the identity of the person to act as the sole arbitrator under the arbitration.

10.6 In the event that the Master Committee fails to reach Consensus on the identity of the sole arbitrator, any Party may, at any time after fourteen (14) business days from the earlier of the due date and date of receipt of a response to a submission to arbitration under paragraph 10.5, request, by Originating Notice, the Chief Justice, or Associate Chief Justice, of the Court of Queens Bench of Alberta, to appoint the sole arbitrator.

10.7 Notwithstanding anything to the contrary, the Master Committee may by Consensus extend any timeframe prescribed or required in this Article.

10.8 The arbitrator shall conduct the arbitration and hear and determine the Issues in private.

10.9 The arbitrator shall render a decision in writing within thirty (30) days of the end of the hearing. The decision of the arbitrator shall be final and binding on the Parties and shall be implemented in the manner provided for in the arbitration decision; provided that the arbitrator shall be entitled to reserve jurisdiction to hear and resolve any disputes arising as a result of the award.

10.10 Each Party shall pay one third of the fees and expenses of the arbitrator.

ARTICLE 11
REOPENING THIS AGREEMENT

11.1 Any Party to this Master Agreement may, within the twelve (12) months before:

(a) The 31st day of March, 2006; and

(b) The 31st day of March, 2008;

open for renegotiation any financial matter of any kind, or other matters or issues upon which the Master Committee reaches Consensus.

11.2 Any Party to this Master Agreement may, not less than twelve (12) months or more than eighteen (18) months before the 31st day of March, 2011 open for renegotiation all matters or issues of any kind.

11.3 Notice to reopen shall be in writing and shall be delivered to the members of the Master Committee in accordance with the provisions hereof, and shall contain a statement of the matters or issues, which the Party giving the notice wishes to re-negotiate.

11.4 Upon receipt of a notice to reopen served pursuant to paragraph 11.1 the Master Committee shall within thirty (30) days meet and determine whether there is Consensus to negotiate respecting any matter or issue other than a financial matter, failing which it shall be deemed that only financial matters are open for renegotiation.

11.5 Upon receipt of a notice to reopen served pursuant to paragraph 11.2 the receiving Parties shall within thirty (30) days advise whether they have any other matters or issues to be included in the negotiations and, if so, include a statement of the matters or issues.

11.6 If no response is received within the time frame set out in paragraph 11.5 it shall be deemed that the non-responding Party or Parties, as the case might be, have no other matters or issues that they wish to negotiate respecting a paragraph 11.2 notice.

11.7 The Parties shall meet within one month of the receipt or deemed receipt of the latest response to a notice to reopen to commence negotiations.

11.8 When dealing with any element of the Master Physician Budget for any Fiscal Year following the 2005/06 Fiscal Year the Arbitrator shall consider, amongst other things:

(a) Prevailing and anticipated economic conditions in Alberta;

(b) Fair and reasonable compensation for Physicians; and

(c) Funding received or to be received by the Department or the Province of Alberta from others and allocated or to be allocated to any Element of the Master Physician Budget.

11.9 The decision of the arbitrator shall, within thirty (30) days of the issuance of the award be incorporated into one or more of an agreement or an amendment to this Master Agreement or a Strategic Physician Agreement as the case might be, which agreement or amending agreement shall be signed by the members of the Master Committee.

11.10 Matters agreed to shall be incorporated into this Master Agreement or a Strategic Physician Agreement as the case might be.

11.11 Each Party shall pay one third of the fees and expenses of any arbitrator.

ARTICLE 12
INFORMATION SHARING

12.1 To the extent permitted by law and, without limitation, the *Health Information Act* (Alberta) each Party will promptly provide in the manner and form directed from time to time by the Master Committee all information and data actually in its possession which is reasonably requested in writing and which is reasonably required by another Party to properly perform its responsibilities or obligations under this Master Agreement or a Strategic Physician Agreement (the "Information").

12.2 Unless otherwise directed by the Master Committee, any Party shall be entitled to require any other Party to enter into a confidentiality agreement respecting all Information provided under paragraph 12.1. This obligation shall not apply to Information that is already in the public domain, other than through the operation of the said paragraph.

ARTICLE 13
INTERPRETATION

13.1 The provisions of Article 13 and Article 14 herein, (excluding paragraphs 13.8 and 14.8 which apply only to this Master Agreement) shall, unless otherwise expressly provided to the contrary, apply to this Master Agreement, a Strategic Physician Agreement and any instruments made and agreements created hereunder or thereunder as the case might be (all such agreements or instruments being individually referred to as an "Agreement" and collectively referred to as the "Agreements").

13.2 Terms in the Agreements with initial capitals have the meanings set out in Schedule "J" attached hereto, unless there is something in the subject matter or context inconsistent therewith.

13.3 In the Agreements, except where expressly otherwise provided or where the fact or context does not permit:

(a) Wherever the singular, plural, masculine, feminine, neuter, body politic or body corporate is used the same shall be construed as meaning the plural, singular, feminine, masculine, neuter, body politic or body corporate as the case might be;

(b) A reference to an individual by his or her name of office means the individual appointed as the person holding that office from time to time or the successor of that office;

(c) A reference to a statute or regulation or a provision thereof means the statute or regulation or provision as amended or superseded from time to time, except where otherwise expressly stated;

(d) A reference to a person includes a body corporate and the Department or the Province of Alberta;

(e) A reference to dollars or amounts of money means lawful money of Canada;

(f) "Herein" or "hereof" or "hereunder" and similar expressions when used in a section shall be construed as referring to the whole of this Agreement and not to that section only, unless otherwise provided; and

(g) Provisions expressed disjunctively shall be construed as including any combination of two or more of them as well as each of them separately.

13.4 In the Agreements, except as otherwise provided herein or by law, the Minister may from time to time perform, exercise, enforce or waive on behalf of the Department any of the rights, powers and privileges conferred on or enjoyed by the Department at law, in equity or by statute.

13.5 Each of the Agreements shall be interpreted and governed by the laws in force in Canada and the Province of Alberta from time to time applicable hereto.

13.6 The headings of the articles, paragraphs or sub paragraphs of an Agreement are for reference purposes only and do not bear on the interpretation of the articles, paragraphs or sub paragraphs to which they relate.

13.7 The contra proferentum rule shall not apply to the interpretation of the Agreements.

13.8 The recitals and the following schedules are incorporated into and form part of this Master Agreement, save and except for the Prior Agreements which are listed for purposes of greater certainty only, namely:

Schedule “A” Regional Health Authority Signatories to This Master Agreement;

Schedule “B” Prior Agreements;

Schedule "C" Master Physician Budgets

Schedule "D" Legacy Alternate Payment Plans;

Schedule "E" Physician Services Agreement;

Schedule "F" Physician Office System Program Agreement;

Schedule "G" Primary Care Initiative Agreement;

Schedule "H" Physician On Call Programs Agreement;

Schedule "I" Existing Physician Recruitment Plans;

Schedule "J" Definitions; and

Schedule "K" Addresses for Notice Pursuant to Paragraph 14.4.

ARTICLE 14
GENERAL PROVISIONS

14.1 An Agreement may be altered or amended in any of its provisions when such changes are reduced to writing and signed by the members of the Master Committee, but not otherwise.

14.2 The Agreements shall enure to the benefit of and be binding upon the Parties hereto and their respective successors.

14.3 Each of the Agreements contains the entire agreement between the Parties hereto relating to the subject matter thereof and there are no oral agreements, statements, representations, warranties, collateral agreements, undertakings, conditions or agreements whatsoever respecting the subject matter hereof other than expressed therein.

14.4 Any notice required to be given under an Agreement by any Party shall be in writing and shall be deemed to have been well and sufficiently given if:

(a) Personally delivered to the Party to whom it is intended or if such Party is a society or body corporate to an officer of that society or body corporate;

(b) Mailed by prepaid registered mail, to the address of the Party to whom it is intended as set forth in Schedule "K" attached hereto; or

(c) Sent by facsimile, to the facsimile number of the Party to whom it is intended as set forth in Schedule "K" attached hereto;

or to such other address or facsimile number as a Party may from time to time direct in writing.

Any notice:

(d) Personally delivered as aforesaid shall be deemed to have been received on the date of delivery;

(e) Mailed shall be deemed to have been received seventy two (72) hours after the date it is postmarked. If normal mail service is interrupted by strike, slow-down, force majeure or other cause after the notice has been sent the notice will not be deemed to be received until actually received; or

(f) Forwarded by facsimile shall be deemed to have been received on the business day next following dispatch and acknowledgment of receipt by the sender's facsimile machine.

In the event any of such means of communication is impaired at the time of sending the notice, the Party sending the notice shall utilize any other service which has not been so impaired so as to ensure prompt receipt thereof.

14.5 No provision of an Agreement shall be deemed to be waived unless such waiver is in writing. Any waiver of any default committed by any of the Parties hereto in the observance or performance of an Agreements shall not extend nor be deemed to extend to or affect any other default.

14.6 Any covenant or provision hereof determined to be void or unenforceable in whole or in part shall not be deemed to affect or impair the validity of an Agreement or any other covenant or provision hereof and the covenants and provisions hereof are declared to be separate and distinct.

14.7 Time is and shall remain of the essence of the Agreements.

14.8 This Master Agreement may be executed in any number of counterparts each of which, when so executed and delivered to the Department, shall be deemed to be an original and all such counterparts shall constitute one and the same instrument and, notwithstanding the date of actual execution, shall be deemed effective as of the Effective Date. A facsimile copy of such counterpart signature when received by the Department shall be deemed to be as valid as an originally executed counterpart.

14.9 The Prior Agreements are terminated and superseded by this Master Agreement on the Effective Date.

IN WITNESS WHEREOF the **Alberta Medical Association (C.M.A. Alberta Division)** has affixed its corporate seal, attested by the hands of its duly authorized officers, and the **Regional Health Authorities** identified in the attached Schedule "A" have each affixed their respective corporate seal, attested by the hands of their respective duly authorized officers and this Master Agreement has been signed on behalf of **Her Majesty the Queen in Right of Alberta** as represented by the Minister of Health and Wellness, all such execution to be effective as of the Effective Date.

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PER: _____

CALGARY HEALTH REGION

PER: _____

CAPITAL HEALTH

PER: _____

CHINOOK REGIONAL HEALTH AUTHORITY

PER: _____

DAVID THOMPSON REGIONAL HEALTH AUTHORITY

PER: _____

EAST CENTRAL HEALTH

PER: _____

NORTHERN LIGHTS HEALTH REGION

PER: _____

PALLISER HEALTH REGION

PER: _____

PEACE COUNTRY HEALTH

PER: _____

THE ALBERTA MEDICAL ASSOCIATION (C.M.A. Alberta Division)

PER: _____

HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA as represented by the Minister of Health and Wellness

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HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA as represented by the Minister of Health and Wellness

PER: _____

MASTER AGREEMENT REGARDING THE TRI-LATERAL RELATIONSHIP AND BUDGET MANAGEMENT PROCESS FOR STRATEGIC PHYSICIAN AGREEMENTS

MADE EFFECTIVE APRIL 1, 2003

SCHEDULE "A"

REGIONAL HEALTH AUTHORITY SIGNATORIES

- Aspen Regional Health Authority
- Calgary Health Region
- Capital Health
- Chinook Regional Health Authority
- David Thompson Regional Health Authority
- East Central Health
- Northern Lights Health Region
- Palliser Health Region
- Peace Country Health

MASTER AGREEMENT REGARDING THE TRI-LATERAL RELATIONSHIP AND BUDGET MANAGEMENT PROCESS FOR STRATEGIC PHYSICIAN AGREEMENTS

MADE EFFECTIVE APRIL 1, 2003

SCHEDULE "B"

PRIOR AGREEMENTS

- Agreement made between the Department and the Association dated for reference the 20th day of April, 1998 as amended by:
    - That Memorandum of Agreement executed January 21, 2001 as incorporated into that Amending Agreement dated for reference the 21st day of January, 2001;
    - That Letter of Understanding dated March 25, 2002 relating to the application of the Default Price Adjustment Mechanism;
    - That Amending Agreement made as of March 31, 2002; and
    - That letter dated August 22, 2002 relating to continuation of the Benefit Stream for the 2003/04 Fiscal Year.

MASTER AGREEMENT REGARDING THE TRI-LATERAL RELATIONSHIP AND BUDGET MANAGEMENT PROCESS FOR STRATEGIC PHYSICIAN AGREEMENTS

MADE EFFECTIVE APRIL 1, 2003

SCHEDULE "C"

MASTER PHYSICIAN BUDGETS

FISCAL YEARS 2003/04 TO 2005/06

The Master Physician Budgets for the above Fiscal Years shall, subject to adjustment as set out in the Master Agreement, consist of the following Elements and sub Elements as the case might be namely:

1. For the 2003/04 Fiscal Year, the aggregate amount of $1,455,700,000 of which:

   (a) $1,341,800,000 will comprise the Physician Services Budget, consisting of:

      (i) Insured Services:

A.	Base	$1,259,300,000
B.	Rate Increase	$32,400,000
C.	Population-Based Volume Increase	$25,200,000

      (ii) Benefit Programs:

A.	Base	$22,800,000
B.	Increase	$2,100,000

   (b) $25,000,000 will comprise the Physician Office System Program Budget;

   (c) $20,000,000 will comprise the Primary Care Initiative Budget; and

   (d) $68,900,000 will comprise the Physician On Call Programs Budget, consisting of:

      (i) On-Call

A.	Base	$63,400,000
B.	Increase	$5,500,000

2. For the 2004/05 Fiscal Year the aggregate amount of $1,521,600,000 of which:

(a) $1,409,700,000 will comprise the Physician Services Budget, consisting of:

(i) Insured Services:

A.	Base	$1,316,900,000
B.	Rate Increase	$36,200,000
C.	Population-Based Volume Increase	$25,200,000

(ii) Insured Service Changes:

A.	Surcharges	$5,000,000
B.	Other support for primary and specialist care	$1,500,000

(iii) Benefit Programs:

(i)	Base	$24,900,000

(b) $20,000,000 will comprise the Physician Office System Program Budget;

(c) $20,500,000 will comprise the Primary Care Initiative Budget, of which amount the sum of $5,000,000 will be targeted to specialist support; and

(d) $71,400,000 will comprise the Physician On Call Programs Budget, consisting of:

(i) On-Call:

A.	Base	$68,900,000
B.	Increase	$2,500,000

3. For the 2005/06 Fiscal Year the aggregate amount of $1,652,000,000 of which:

(a) $1,496,600,000 will comprise the Physician Services Budget consisting of the following sub elements:

(i) Insured Services:

A.	Base	$1,384,800,000
B.	Rate Increase	$42,600,000
C.	Population-Based Volume Increase	$30,300,000

(ii) Insured Service Changes:

A.	Surcharges	$ 5,000,000
B.	Other support for primary and specialist care	$7,400,000

(iii) Benefit Programs:

A.	Base	$24,900,000
B.	Increase	$1,600,000

(b) $20,600,000 will comprise the Physician Office System Program Budget;

(c) $59,500,000 will comprise the Primary Care Initiative Budget, of which amount the sum of $5,000,000 will be targeted to specialist support; and

(d) $75,300,000 will comprise the Physician On Call Programs Budget, consisting of:

(i) On-Call:

A.	Base	$71,400,000
B.	Increase	$3,900,000

MASTER AGREEMENT REGARDING THE TRI-LATERAL RELATIONSHIP AND BUDGET MANAGEMENT PROCESS FOR STRATEGIC PHYSICIAN AGREEMENTS

MADE EFFECTIVE APRIL 1, 2003

SCHEDULE "D"

LISTING OF LEGACY ALTERNATE PAYMENT PLANS

Northern Lights Health Region

- Ft. McMurray General Hospital

Calgary Health Region

- Alexandra Community Health Centre
- Alberta's Children's Hospital – Group Psychiatry
- Alberta Children's Hospital – DAT
- Foothills Hospital – Neonatology
- Foothills Hospital – Psychiatric/Substance Abuse
- Calgary General Hospital – Psychiatry
- Calgary District Hospital Group – Psychiatry
- SARGP – Geriatric
- Calgary Urban Project Society
- U of C Traveling Psychiatric Clinic

Chinook Regional Health Authority

- Geriatric/Psychiatry
- Geriatric Program Physicians
- Lethbridge Hospital – Psychiatric Session

Capital Health

- Boyle McCauley Health Centre
- Capital Care – Mewburn
- Caritas – EGH – Palliative Care
- Caritas – Psychiatric Sessions
- Glenrose – Geriatric Services
- UAH – Pediatric Cardiology

- UAH – Psychiatric Sessions
- UAH – Pediatric Intensive Care
- Neonatal Intensive Care

David Thompson Regional Health Authority

- Red Deer General Hospital

Palliser Health Region

- Medicine Hat General Hospital

MASTER AGREEMENT REGARDING THE TRI-LATERAL RELATIONSHIP AND BUDGET MANAGEMENT PROCESS FOR STRATEGIC PHYSICIAN AGREEMENTS

MADE EFFECTIVE APRIL 1, 2003

SCHEDULE "E"

PHYSICIAN SERVICES AGREEMENT

The text of Schedule "E" commences on the immediately following page.

PHYSICIAN SERVICES AGREEMENT MADE EFFECTIVE THE 1ST DAY OF APRIL, 2003

AMONGST:

HER MAJESTY THE QUEEN
IN RIGHT OF ALBERTA
as represented by the
MINISTER OF HEALTH AND WELLNESS
(the "Department")

And

THE ALBERTA MEDICAL ASSOCIATION
(C.M.A. Alberta Division)
(the "Association")

And

THOSE REGIONAL HEALTH AUTHORITIES
IDENTIFIED IN SCHEDULE "A"
ATTACHED TO THE MASTER AGREEMENT
(the "Authorities")

RECITALS:

A. The Parties have entered into a Master Agreement regarding the Tri-Lateral Relationship and Budget Management Process for Strategic Physician Agreements (the "Master Agreement") dated for reference the 1st day of April, 2003; and

B. The Master Agreement contemplates that the Parties will enter into this Strategic Physician Agreement respecting the Physician Services Budget.

THEREFORE, the Parties promise and agree with each other as follows:

ARTICLE 1.
DEFINITIONS AND INTERPRETATION

1.1 In this Agreement terms with initial capitals and defined in Schedule "J" to the Master Agreement have the meanings ascribed to such terms therein and the following terms have the meanings set out herein, unless there is something in the subject matter or context inconsistent therewith:

(a) "**Agreement**" means this Physician Services Agreement and any appendices annexed hereto; and

(b) "**Committee**" means the Physician Services Committee formed pursuant to paragraph 4.1(a) of the Master Agreement with responsibility for the management and administration of this Agreement and the Physician Services Budget as more particularly set out in Schedule "C" to the Master Agreement.

1.2 The interpretative provisions set out in Article 13 (except the provisions of paragraph 13.8) and the general provisions set out in Article 14 (except the provisions of paragraph 14.8) of the Master Agreement are incorporated into and form part of this Agreement.

1.3 The recitals and the following appendices are incorporated into and form part of this Agreement:

Appendix "A" Description and Objectives of Benefit Plans;

ARTICLE 2.
TERM

2.1 The term of this Agreement shall commence on the Effective Date and shall, notwithstanding any notice to reopen negotiations served pursuant to paragraph 11.2 of the Master Agreement, remain in full force and effect only until twelve (12) o'clock midnight March 31, 2011.

ARTICLE 3.
PHYSICIAN SERVICES COMMITTEE

3.1 The Committee shall deal with all matters related to the expenditure of monies comprising the Physician Services Budget, or any Element thereof, including but not limited to:

(a) Expenditures and utilization in respect of Insured Services and Benefit Plans;

(b) Fees set out in the Schedule, Provincial Payment Rates and conditions of payment for Insured Services;

(c) Reports or recommendations concerning requests for supplements from the Insured Services Element; provided always that the Committee shall not be empowered to make any final decision respecting a request for such supplement, which decision shall be made only by Consensus of the Master Committee;

(d) Allocation of the amounts listed in item 2(a)(ii) and 3(a)(ii) of Schedule "C" and relating to the Physician Services Budget for Fiscal Years 2004/05 and 2005/06 respectively to be used for:

(i) The revision of surcharge and premium rules and rates; and

(ii) Changes, without limitation, to support the primary and specialty care initiatives including consideration of expansion of the billing of telephone advice to other health care providers; rates for hospitalists, team conferences, shared care, palliative care, and home visits by Physicians;

(e) To provide technical and other information as requested by the Master Committee respecting the inclusion of Insured Services paid through Authority or other budgets into the Physician Services Budget; and

(f) Provide input into the Budget Management and Adjustment Process set out in Article 8 of the Master Agreement or any other matter as requested or directed by the Secretariat or the Master Committee from time to time.

3.2 In the event that the Committee is unable to reach Consensus on any matter properly to be considered by it, that matter shall be forwarded to the Secretariat for consideration.

3.3 Notwithstanding the provisions of paragraph 3.2, any member of the Committee shall be permitted, at any time and from time to time, to require that a matter presently before the Committee be referred to the Secretariat for consideration without the requirement that such matter be brought to a formal vote by the Committee.

3.4 The Committee shall, in accordance with the provisions of paragraph 4.3 of the Master Agreement, prepare a Mandate, having due regard for the provisions of paragraph 3.1 above, recommending its terms of reference, roles and responsibilities.

ARTICLE 4
PHYSICIAN SERVICES BUDGET

4.1 The Parties have agreed that, subject to adjustment, if any, the Physician Services Budget will, at the start of any Fiscal Year, initially be those amounts set out in Schedule "C" and comprising a portion of the Master Physician Budget.

4.2 The Committee will, in accordance with directions received, from time to time, from the Secretariat or the Master Committee as the case might be, monitor, manage and report on the Physician Services Budget.

ARTICLE 5
ALTERNATE RELATIONSHIP PLANS

5.1 The Parties agree to establish Alternate Relationship Plans for the payment of services, including Insured Services. All such Alternate Relationship Plans shall stipulate the eligibility criteria for Physicians to receive payment, the conditions and standards of service and the Provincial Payment Rate.

5.2 The Committee is hereby authorized, subject to considering any recommendations and following any directions of the Secretariat or the Master Committee as the case might be, to approve the terms and conditions under which monies from the Insured Services Element shall be paid under an Alternate Relationship Plan in order to ensure that such funding is fair and equitable in the circumstances.

5.3 The following principles apply to the provision of services, including Insured Services, under an Alternate Relationship Plan, namely:

(a) The Physician's professional autonomy and clinical independence should be protected; and

(b) A Physician shall have the right to be compensated for the provision of Insured Services through fee for service payments, should that Physician no longer be involved in an Alternate Relationship Plan.

5.4 The Parties acknowledge that the provisions of paragraph 5.2 and the principles set out in paragraph 5.3 have been incorporated into those Alternate Relationship Plans existing as of the Effective Date.

5.5 The Committee will review and confirm or establish, as the case might be, the eligibility criteria, conditions and standards of service and Provincial Payment Rates to be utilized under Alternate Relationship Plans. The review and confirmation or establishment , as the case might be, shall be completed by June 30, 2004, or such other date as the Master Committee might from time to time approve.

5.6 Notwithstanding the provisions of paragraphs 5.2 and 5.3 above, the Parties recognize that other considerations may, in the overall best interests of Albertans, require a supplement from the Insured Services Element in respect of Physician Agreements or Alternate Relationship Plans. These considerations may include, but are not limited to:

(a) Market conditions;

(b) Maintaining an appropriate critical mass of Physicians;

(c) Health system changes;

The Committee shall consider all such instances and report or make recommendations to the Secretariat or Master Committee as necessary or desirable.

ARTICLE 6.
BENEFIT PLANS

6.1 The Association is responsible for the administration of the Benefit Plans.

6.2 The Association shall retain the current Benefit Surplus.

6.3 The Parties agree that the Association may use the Benefit Element and the Benefit Surplus to:

(a) Maintain the Benefit Plans set out in Appendix "A" annexed hereto;

(b) Enhance the Physician and Family Support Program; and

(c) Introduce a Parental Leave Program as a Benefit Plan, subject to sufficient monies being available in the Benefit Element and Benefit Surplus.

6.4 For the purposes of this Article "Eligible Physician" means a Physician who, throughout the program year applicable to the Benefit Plan in respect of which an application for benefits is made is a resident of Alberta and is:

(a) Providing Insured Services and receiving payment for these Insured Services through the Insured Services Element; or

(b) Providing laboratory services funded by an Authority;

(c) Employed by the Alberta Cancer Board and providing laboratory services or Insured Services;

(d) Is a Physician as described in paragraph 5.3(f) of the Master Agreement and providing Insured Services under special licensure; or

(e) Is approved by the Department from time to time.

6.5 The Association shall, no later than thirty (30) days after the end of each quarter of each Fiscal Year during the term of this Agreement, provide the Department with internal financial statements respecting the Benefit Element, prepared in accordance with Generally

Accepted Accounting Principles, and certified to be complete and accurate in all respects by the Assistant Executive Director (Corporate Affairs) of the Association,

6.6 The Department shall pay the maximum aggregate amount of the Benefit Element, as adjusted from time to time in accordance with Article 8 of the Master Agreement, to the Association in quarterly installments commencing April 1, 2003, based on cash flow requirements of the Benefit Plans established by the Association and agreed to by the Department.

6.7 All Benefit Element monies received by the Association shall be kept separate and apart from any other monies of the Association in an account established and maintained with a financial institution satisfactory to the Department. The Association may invest surplus monies, if any, not required for the payment of benefits from time to time. In making any investments, the Association shall adhere to investment and lending policies, standards and procedures that a reasonable and prudent person would apply in respect of a portfolio of investments to avoid undue risk of loss and obtain a reasonable return. Any investment gains or earnings shall only be used for the purposes of providing the benefits contemplated by the Benefit Plans or for the payment of the costs of administering the Benefit Plans.

6.8 The Association shall make the Benefit Plans equally available to all Eligible Physicians who desire to take part in same and shall advertise the availability of, and administer, the Benefit Plans in a fair and equitable manner so as to ensure, to the greatest extent reasonably possible, that administrative differences between members and non-members of the Association in respect of participation in such Benefit Plans are minimized.

6.9 The Association shall administer the Benefit Plans in such a manner that no benefits are to be paid to Physicians in respect of any period of time when the said Physician is not an Eligible Physician. The Association shall use its best efforts to recover from any Physician who, during a Benefit Plan program year ceases to be an Eligible Physician, any amounts paid to that Physician in respect of a benefit applicable to a period of time when that Physician is not an Eligible Physician.

6.10 The Department acknowledges that the Association intends to charge non-members an administration fee as a condition of participation in the Benefit Plans. The Association covenants that such administration fee shall not exceed the annual cost of membership

charged by the Association to its members for full membership in the Association.

6.11 The Association shall not be entitled to initiate a new, or discontinue an existing, Benefit Plan without the prior written consent of the Department.

6.12 The Association shall have the authority to:

(a) Transfer or change the allocation of funding between Benefit Plans; provided that the aggregate payments and costs to administer the Benefit Plans will not exceed the amount of the Benefit Element in any Fiscal Year; and

(b) Allocate a reasonable amount for administration costs; provided that such costs shall not exceed 4% of the amount of the Benefit Element plus $400,000 in any Fiscal Year.

6.13 The Association shall:

(a) Within one hundred and twenty (120) days immediately following the end of a Fiscal Year provide to the Department:

(i) audited financial statements in respect of the benefits paid, reserves maintained, the Benefit Surplus, and administrative costs incurred or accrued respecting the Association's administration of the Benefit Element; and

(ii) an evaluation of the Benefit Plans assessing the overall performance and management of the Benefit Plans.

6.14 In addition to the information provided herein, the Association shall provide any other information pertaining to the Benefit Plans or the Benefit Element at such time and in such maner as the Department or the Master Committee may reasonably require.

6.15 The Association shall make available copies of the financial statements referred to in paragraph 6.13(a)(i) to all Physicians who are members of the Association or who have participated in a Benefit Plan during the Fiscal Year to which the financial statements relate. The Association may satisfy its obligations under this paragraph by making electronic copies of the said audited financial statements available through the Internet; provided that the Association notifies its members and all non-member Physicians who participate in a Benefit Plan in writing that the said financial statements are so available and that paper copies will be provided to any Physician so requesting.

6.16 With respect to the Benefit Plans and in accordance with Article 12 of the Master Agreement, the Department shall provide to the Association an electronic list of Physicians deemed eligible to receive benefits, including those Physicians receiving payments for

Insured Services through the Insured Services Element; provided always that the Department shall bear no liability for errors or omissions in respect of Physicians whose services are charged fee for service through a common billing number or similar joint arrangement.

6.17 The Association shall use its best efforts to ensure that any dividend, premium rebate, refund, or surplus arising in respect of assistance provided to Physicians under the Medical Liability Reimbursement Program shall be paid to the Association, form part of the Benefit Element, and be utilized only as contemplated under the provisions of this Article.

6.18 The Association shall administer the Benefit Plans in such a manner as to fulfill the goals, objectives and criteria set out in Appendix "A" attached hereto.

6.19 The Department and the Association shall equally share the costs and expenses related to the development of the Best Practice Initiative Program under the provisions of this Article up to a maximum of $750,000 per Fiscal Year for the said program.

6.20 The Association's share of the amount referred to in paragraph 6.19 is included in the Benefit Element and the Department's share shall be in addition to any amount included in the Master Physician Budget and shall be paid for deposit into the account referred to in paragraph 6.7.

Appendix "A"

To that Physicians Services Agreement
Made Effective the 1st day of April, 2003

DESCRIPTION AND OBJECTIVES OF BENEFIT PLANS

1. MEDICAL LIABILITY REIMBURSEMENT PROGRAM

To reimburse Eligible Physicians for costs incurred in respect of medical liability insurance premiums. The annual deductible will be $1,000 per Eligible Physician.

2. CONTINUING MEDICAL EDUCATION

To reimburse eligible Physicians for costs incurred with regard to the maintenance and enhancement of knowledge, skills and competency. The annual allotment shall be a minimum of $1,300 to be carried forward and accumulated for up to three years.

3. COMPASSIONATE EXPENSE PROGRAM

To assist, on compassionate grounds, Eligible Physicians in need of temporary support who have been referred by either the College or a consulting Physician of the Physician and Family Support Program.

4. BEST PRACTICES INITIATIVES PROGRAM (Formerly Clinical Practice Guidelines Program)

To support the development, implementation and evaluation of products and services that will facilitate evidence-based best practice and support quality initiatives in medical care in Alberta.

5. RURAL LOCUM PROGRAM

To ensure that Residents living in communities with four or fewer Physicians will have access to continuous medical coverage if a Physician is unable to provide Physician services due to short term absences. Any initiatives through the Rural Locum Program should be consistent with Rural Physician Action Plan initiatives.

6. SPECIALIST LOCUM PROGRAM

To ensure regional centres outside Calgary and Edmonton will have access to specialist coverage due to short term absenses of specialists in regional centres. Local specialists in consultation with regional medical directors agree on locum needs.

7. PHYSICIAN AND FAMILY SUPPORT PROGRAM

To provide Eligible Physicians, and their qualified dependents with assistance in dealing with life management issues.

8. PARENTAL LEAVE PROGRAM

To provide financial support to Eligible Physicians who are not practicing medicine as a result of the birth or adoption of a child.

MASTER AGREEMENT REGARDING THE TRI-LATERAL RELATIONSHIP AND BUDGET MANAGEMENT PROCESS FOR STRATEGIC PHYSICIAN AGREEMENTS

MADE EFFECTIVE APRIL 1, 2003

SCHEDULE "F"

PHYSICIAN OFFICE SYSTEM PROGRAM AGREEMENT

The text of Schedule "F" commences on the immediately following page.

PHYSICIAN OFFICE SYSTEM PROGRAM AGREEMENT MADE EFFECTIVE THE 1ST DAY OF APRIL, 2003

AMONGST:

HER MAJESTY THE QUEEN
IN RIGHT OF ALBERTA
as represented by the
MINISTER OF HEALTH AND WELLNESS
(the "Department")

And

THE ALBERTA MEDICAL ASSOCIATION
(C.M.A. Alberta Division)
(the "Association")

And

THOSE REGIONAL HEALTH AUTHORITIES
IDENTIFIED IN SCHEDULE "A"
ATTACHED TO THE MASTER AGREEMENT
(the "Authorities")

RECITALS:

A. The Parties have entered into the Master Agreement regarding the Tri-Lateral Relationship and Budget Management Process for Strategic Physician Agreements (the "Master Agreement") effective the 1st day of April, 2003;

B. The Master Agreement contemplates that the Parties will enter into this Physician Office System Program Agreement;

C. The Physician Office System Program started under a Prior Agreement and the Parties desire that it continue and be extended under the provisions of the Master Agreement and this Agreement.

THEREFORE, the Parties promise and agree with each other as follows:

ARTICLE 1.
DEFINITIONS AND INTERPRETATION

1.1 In this Agreement terms with initial capitals and defined in Schedule "J" to the Master Agreement have the meanings ascribed to such terms therein and the following terms have the meanings set out herein, unless there is something in the subject matter or context inconsistent therewith:

(a) "**Agreement**" means this Physician Office System Program Agreement and any appendices annexed hereto;

(b) "**Committee**" means the Physician Office System Program Committee formed pursuant to paragraph 4.1(b) of the Master Agreement with responsibility for the management and administration of this Agreement and the POSP Element to be utilized for the purposes of the Program;

(c) "**Local Primary Care Initiative**" or "**LPCI**" means arrangements between Authorities and participating Physicians pursuant to the terms of the Primary Care Initiative Agreement made pursuant to paragraph 5.1(c) of the Master Agreement;

(d) "**POSP**" or the "**Program**" means the Physician Office System Program as described in this Agreement and detailed Program Guidelines;

(e) "**POSP Element**" means that portion of the Master Physician Budget allocated to the Program as more particularly set out in Schedule "C" to the Master Agreement;

(f) "**Program Director**" means the person retained by the Association with responsibility for POSP administration on behalf of the Parties in accordance with the position and person profile approved from time to time by the Committee;

(g) "**Program Guidelines**" means the document entitled *POSP Program Guidelines,* published October 1, 2001, as amended from time to time and approved by the Committee;

(h) "**Program Recipient**" means an individual Physician or group of Physicians who submit a successful application and receive funding from the POSP Element; and

(i) "**Reference Price**" means the price established by the Committee to represent amortization on investment for hardware, software and operating costs for network connectivity;

1.2 The interpretative provisions set out in Article 13 (except the provisions of paragraph 13.8) and the general provisions set out in Article 14 (except the provisions of paragraph 14.8) of the Master Agreement are incorporated into and form part of this Memorandum.

1.3 The recitals are incorporated into and form part of this Agreement.

ARTICLE 2.
TERM

2.1 The term of this Agreement shall commence on the Effective Date and shall,

notwithstanding any notice to reopen negotiations served pursuant to paragraph 11.2 of the Master Agreement, remain in full force and effect only until twelve (12) o'clock midnight March 31, 2011.

ARTICLE 3.
POSP COMMITTEE

3.1 The Committee shall have general management and supervision of the Program and all matters relating to the expenditure of the monies held by the Association as set out in paragraph 6.1 hereof and the POSP Budget.

3.2 In the event that the Committee is unable to reach Consensus on any matter properly to be considered by it, that matter shall be forwarded to the Secretariat for consideration.

3.3 Notwithstanding the provisions of paragraph 3.2, any member of the Committee shall be permitted, at any time and from time to time, to require that a matter presently before the Committee be referred to the Secretariat for consideration without the requirement that such matter be brought to a formal vote by the Committee.

3.4 The Committee shall, in accordance with the provisions of paragraph 4.3 of the Master Agreement, prepare a Mandate, having due regards for the provisions of paragraph 3.1 above, recommending its terms of reference, roles and responsibilities.

3.5 The Committee will review whether any prospective adjustment needs to be made to the Reference Price for any level within the POSP Budget and provide its report or recommendations to the Master Committee not later than October 1, 2004 and such other times during the term of this Agreement as might be determined by the Committee or requested by the Master Committee.

3.6 Provide input into the budget management and adjustment process set out in Article 8 of the Master Agreement or any other matter as requested or directed by the Secretariat or the Master Committee from time to time.

ARTICLE 4
PROGRAM VISION, GOALS AND PRINCIPLES

4.1 The Parties agree to continue and maintain the Program in accordance with the outcomes and guiding principles set out in paragraphs 4.3 and 5.2 hereof.

4.2 The scope of the Program shall not be amended without the prior written consent of the Master Committee.

4.3 Desired outcomes of the Program to be targeted during the three years commencing on the Effective Date will be to:

(a) Improve quality of care and enhance patient safety;

(b) Increase efficiency and clinical competency in service delivery;

(c) Improve management and access to practice information; and

(d) Ensure reliable and confidential Electronic Medical Records ("EMR").

4.4 The Parties will encourage and support use of EMR by Physicians enrolled under POSP according to prescribed targets established from time to time by the Master Committee.

4.5 The Parties shall encourage the use of the electronic health record, as available, within all levels of automation.

4.6 POSP will reasonably, fairly and objectively support all participation levels and product offerings.

4.7 The Association shall enter into funding agreements with Physicians as Program Recipients substantially in the form approved from time to time by the Committee.

4.8 The Committee may approve participation in the Program by Physicians who are in an Authority, university or other institutional setting, on a prospective basis. Funding under the Program shall not be provided for software or equipment being used by a Program Recipient in an Authority, university or other institutional setting at the time of the application for initial funding.

4.9 No Physician shall be entitled to receive funding in respect of any software or equipment for or in respect of which funding or support from other sources has been received.

4.10 Authorities will remain accountable to the Department to the extent of their electronic health record obligations under their respective multi-year performance agreements during the term of this Agreement, including preparation of annual reports on access and use of POSP by all Physicians participating in an LPCI.

ARTICLE 5
ENROLMENT TARGETS

5.1 The POSP Committee will deliver a comprehensive plan for the Program to the Master Committee by December 31, 2003, or such other date as the Master Committee might establish from time to time, that reflects a health system perspective and includes detail on targeted Program outcomes and Physician outcomes, together with an estimate of Program enrolment through to March 31, 2006.

5.2 The plan referred to in paragraph 5.1 will be developed with consideration of the following guiding principles:

(a) Optimizing the number of Program Recipients;

(b) Maximizing the percentage of funding dollars allocated to support Physicians;

(c) Maximizing the impact on quality of care or the care delivery process; and

(d) An ongoing commitment to evaluation and development of evidence regarding the impact of POSP.

5.3 Selection of Program Recipients will continue to be administered by an appropriate staging process. The Program will choose Program Recipients in the following order of priority, subject to such participants meeting all other Program criteria, eligibility requirements and conditions, namely:

(a) Physicians participating in or intending to participate in LPCIs established pursuant to the Primary Care Initiative Agreement referred to in paragraph 5.1(c) of the Master Agreement as identified to the Committee by the Primary Care Initiative Committee;

(b) Physicians wishing to participate in the provincial electronic health record initiative;

(c) New graduate Physicians; and

(d) Any other priorities as may be determined by the Master Committee.

ARTICLE 6
FUNDING

6.1 The Association acknowledges that, as of the Effective Date, it held the sum of $6,249,073 for the purposes of the Program.

6.2 Subject always to adjustment, if any, as contemplated under the Master Agreement, the POSP Budget for each Fiscal Year shall be as set out in Schedule "C" to the Master Agreement.

6.3 The POSP Budget shall be provided to the Association pursuant to the terms of a grant agreement to be entered into with the Department. The Grant Agreement shall be consistent with the provisions of the Master Agreement and this Agreement, and in a form satisfactory to the Department, acting reasonably.

6.4 All Program Recipients accepted in POSP, both before and after the Effective Date, will be entitled to forty eight (48) months of funding, subject to compliance with Program Recipient obligations established for POSP.

6.5 Program Recipients who have received forty eight (48) months of funding prior to March 31, 2006 will be eligible for expansion of Program funding, if any, that comes into effect in Fiscal 2006/07. Cessation of funding prior to the time of Program expansion, if any, shall not prevent renewed funding if approved by the Master Committee.

6.6 The Association shall use funding held pursuant to paragraph 6.1 above and monies received from the POSP Budget together with any interest earned thereon only for the purposes set out in this Agreement or as otherwise approved by the Master Committee from time to time.

ARTICLE 7
ASSOCIATION AND PHYSICIAN CONTRIBUTIONS

7.1 Each Program Recipient shall be required to commit funds according to the applicable Reference Price related to each level and to be entitled to reimbursement of the attributed portion from the POSP Budget under the processes established by the Committee.

7.2 The Association agrees to contribute in kind towards:

(a) Change management costs to assist Physicians participating in the Program;

(b) Formatting and presentation of clinical decision support tools using IM/IT, including access to best practices initiatives; and

(c) Development of Association initiatives to otherwise assist Physicians with the use of technology to improve patient care services.

ARTICLE 8
STANDARDS

8.1 The Parties agree to implement the Vendor Conformance and Usability Requirements ("VCUR") and accreditation/conformance process not later than March 31, 2004. Once VCUR is defined and established, no new Program Recipient will be funded under POSP unless such participant conforms to VCUR standards or such other standards that are specified by the POSP Committee.

8.2 The Program will require that participating Physician information management and technology practices and processes comply with:

(a) Provincially approved standards as endorsed by the Health Information Standards Committee for Alberta (HISCA);

(b) All federal and provincial legislation, and

(c) All published information exchange standards including messaging and security.

ARTICLE 9
FEDERAL OR OTHER FUNDING

9.1 The parties will use their collective best efforts to structure and administer the Program to optimize all opportunities for financial assistance from any federal or other funding program, including without limitation, any projects initiated under the auspices of Infoway or similar agency; provided always that acceptance of such funding will not contravene the provisions of this Agreement or the Committee's Mandate.

ARTICLE 10
PUBLICATION, DISSEMINATION AND RELEASE OF INFORMATION

10.1 The Department shall be given public credit for supporting the Program in any of its aspects. The form of such credit shall be satisfactory to the Department, acting reasonably. In the event of a disagreement the matter shall be referred to the Master Committee for resolution.

10.2 The Parties will continue to apply best efforts at reaching full agreement on outstanding issues concerning privacy issues and the protection of the integrity of the Physician/patient relationship.

MASTER AGREEMENT REGARDING THE TRI-LATERAL RELATIONSHIP AND BUDGET MANAGEMENT PROCESS FOR STRATEGIC PHYSICIAN AGREEMENTS

MADE EFFECTIVE APRIL 1, 2003

SCHEDULE "G"

PRIMARY CARE INITIATIVE AGREEMENT

The text of Schedule "G" commences on the immediately following page.

PRIMARY CARE INITIATIVE AGREEMENT MADE EFFECTIVE THE 1ST DAY OF APRIL, 2003

AMONGST:

HER MAJESTY THE QUEEN
IN RIGHT OF ALBERTA
As represented by the
MINISTER OF HEALTH AND WELLNESS
(the "Department")

And

THE ALBERTA MEDICAL ASSOCIATION
(C.M.A. ALBERTA DIVISION)
(the "Association")

And

THOSE REGIONAL HEALTH AUTHORITIES
IDENTIFIED IN SCHEDULE "A"
ATTACHED TO THE MASTER AGREEMENT
(the "Authorities")

RECITALS:

A. The parties have entered into a Master Agreement regarding the Tri-Lateral Relationship and Budget Management Process for Strategic Physician Agreements (the "Master Agreement") dated for reference the 1st day of April, 2003; and

B. The Master Agreement contemplates that the parties will enter into this Strategic Physician Agreement respecting the Primary Care Initiative.

THEREFORE the Parties promise and agree with each other as follows:

ARTICLE 1
DEFINITIONS AND INTERPRETATION

1.1 In this Agreement terms with initial capitals and defined in Schedule "J" to the Master Agreement have the meanings ascribed to such terms therein and the following terms have the meanings set out herein, unless there is something in the subject matter or context inconsistent therewith:

(a) "**Agreement**" means this Primary Care Initiative Agreement, and any appendices annexed hereto;

(b) "**Annual Per Capita Amount**" means the annual amount provided to an LPCI on a per capita basis for those members of a specific Patient Population;

(c) "**Business Plan**" means a document submitted by a Participating Physician and an Authority in a manner, form and content prescribed by the Committee and substantially meeting the criteria defined in Article 7;

(d) "**Change Management Funding**" means the funding established by the Committee as referred to in Article 10;

(e) "**Committee**" means the Primary Care Initiative Committee formed pursuant to paragraph 4.1(c) of the Master Agreement with responsibility for the management and administration of this Agreement and the Primary Care Initiative Budget as more particularly set out in Schedule "C" to the Master Agreement;

(f) "**Encounter**" means the unit of measure, determined by the Committee, for the provision of Service Responsibilities through an LPCI, to be used in determining eligibility of Patients to be included in an Enrolment List;

(g) "**Enrolment Agreement**" means a document signed by or on behalf of a Patient, in form and content satisfactory to the Committee, which evidences that the person or persons named in the document have chosen to be Formally Enrolled with and obtain Services from an LPCI;

(h) "**Enrolment List**" means the list of the Patient Population in respect of which an LPCI is obligated to provide the Service Responsibilities and to receive LPCI Funding based on the Annual Per Capita Amount;

(i) "**Formal Enrolment**" or "**Formally Enrolled**" means that a Patient has signed an Enrolment Agreement with an LPCI;

(j) "**Formal Enrolment List**" means the Patients on the Enrolment List of an LPCI who are Formally Enrolled;

(k) "**Informal Enrolment**" or "**Informally Enrolled**" means that a Patient is eligible to be included on an Enrolment List, but has not signed an Enrolment Agreement;

(l) "**Informal Enrolment List**" means the Patients on the Enrolment List on an LPCI who are Informally Enrolled;

(m) "**Initiative**" means the primary care initiative contemplated under this Agreement and to be funded from the Primary Care Initiative Budget or any Element thereof;

(n) "**LPCI**" means the contractual arrangement between a Participating Physician and an Authority acting together to provide the Service Responsibilities;

(o) **"Majority Care Provider**" means an LPCI, that in respect to a Patient, provides fifty (50%) percent or greater of the Encounters relating to the provision of primary care services with that Patient;

(p) **"Patient"** means a Resident who receives or is entitled to receive Insured Services;

(q) "**Participating Physician**" means a Physician who has signed an approved Letter of Intent or an approved Business Plan or both;

(r) "**Patient Population**" means those Patients who are Formally or Informally Enrolled and receiving or entitled to receive Services from an LPCI;

(s) "**Services**" means, in respect of a Patient, the receipt or ability to receive those Service Responsibilities to be provided by an LPCI in respect of its Patient Population; and

(t) "**Service Responsibilities**" means, in respect of an LPCI, those services defined from time to time by the Committee to be provided by every LPCI as initially set out in Article 8 hereof.

1.2 The interpretive provisions set out in Article 13 (except the provisions of paragraph 13.8) and the general provisions set out in Article 14 (except the provisions of paragraph 14.8) of the Master Agreement are incorporated and form part of this Agreement.

1.3 The recitals are incorporated into and form part of this Agreement.

ARTICLE 2
TERM

2.1 The term of this Agreement shall commence on the Effective Date and shall, not withstanding any notice to reopen negotiations served pursuant to paragraph 11.2 of the Master Agreement, remain in full force and effect only until twelve (12) o'clock midnight, March 31, 2011.

ARTICLE 3
ACKNOWLEDGEMENTS

3.1 The Parties acknowledge and confirm that:

(a) Alberta has taken a leadership role relative to other provinces in many key aspects of health care improvement, including information management and technology;

(b) relationships among government, regional health authorities and providers are recognized as being among the best in the country;

(c) A number of areas for improvement to the health care system have been identified, including:

(i) access to many providers, including finding a family Physician, is becoming more limited as the population grows;

(ii) fewer medical students are choosing to practise in family medicine for a variety of reasons; and

(iii) while many of the individual system components are excellent, there is a need for better co-ordination and integration, for example, between regional programs and Physician offices;

(d) A strong patient-Physician relationship is a fundamental building block for primary care improvement and every Albertan should be encouraged to establish a relationship with a family Physician;

(e) The key objectives of the Initiative are to:

(i) increase the proportion of Residents with ready access to primary care;

(ii) provide coordinated 24-hour, 7-day-per-week management of access to appropriate primary care services;

(iii) increase the emphasis on health promotion, disease and injury prevention, care of the medically complex Patient and care of Patients with chronic disease;

(iv) improve coordination and integration with other health care services including secondary, tertiary and long-term care through specialty care linkages to primary care; and

(v) facilitate the greater use of multi-disciplinary teams to provide comprehensive primary care;

(f) A number of reports, such as the report of the Premier's Advisory Council on Health in Alberta (Mazankowski report) and the federal reports from the Standing Senate Committee on Social Affairs, Science and Technology (Kirby Report) and the Commission on the Future of Health Care in Canada (Romanow Report) have reinforced the need for primary care improvement and the general directions of that improvement;

(g) Family Physicians are specially trained in the coordination of primary care services, are skilled at providing information that empowers Patients to take charge of their own health care and are able to develop a comprehensive approach to the management of disease and illness; and

(h) Innovation and delivery must occur at the local levels regarding the cooperative efforts and sharing of resources between Authorities and Physicians.

ARTICLE 4
PRIMARY CARE INITIATIVE COMMITTEE

4.1 The Committee shall deal with the expenditure of monies comprising the Primary Care Initiative Budget and all matters related to the Initiative, including but not limited to:

(a) Support the development of LPCIs involving Participating Physicians and Authorities for the provision of primary care to a defined population;

(b) Structure and administer LPCIs to optimize all opportunities for financial contribution from any federal funding program;

(c) Day-to-day administration and support of the Initiative;

(d) Establish (and amend as required) province-wide standards for LPCIs including:

(i) defining the criteria to be included in a Letter Of Intent as initially set out in Article 6;

(ii) developing standardized Change Management Funding amounts for Business Plan development;

(iii) defining the criteria to be included in a Business Plan as initially set out in Article 7;

(iv) defining the Service Responsibilities substantially as initially set out in Article 8;

(v) determine the process to select among the initial submissions of Letters of Intent;

(vi) developing mechanisms and incentives to recognize the value-added services in specialist linkages to LPCIs;

(vii) developing descriptions and suggested rates for value-added services provided by Participating Physicians not funded from the Insured Services Element including supervision of alternate providers, administration, travel and 24-hour, 7-day-per-week management of access;

(viii) developing contractual templates for primary care initiatives and specialist care initiatives;

(ix) developing standardized forms and criteria for the enrolment of members to a Patient Population; and

(x) developing or refining Encounter, and proration amount definitions related to the enrolment of and payment for the Patient Population;

(e) Receive and approve Letters of Intent submitted by a Physician and an Authority and determine and allocate Change Management Funding for Business Plan development;

(f) Establish and fund a provincial change management program to assist Physicians and Authorities in developing their Letters of Intent or Business Plans and to assist in the re-evaluation of Business Plans, where necessary;

(g) Review and make recommendations, from time to time, regarding the Annual Per Capita Amount;

(h) Receive and approve Business Plans and amendments thereto submitted by a Participating Physician and an Authority;

(i) Provide information to LPCIs through Department information systems to assist them in determining the service needs of their Patient Population and to assist in ongoing management;

(j) Authorize funding to LPCIs upon approval of their Business Plan in accordance with Article 9 or cessation of such funding if the LPCI does not fulfill its Service Responsibilities;

(k) Develop templates of service delivery models or other tools to promote primary care initiatives and specialist care initiatives;

(l) Establish accountability mechanisms;

(m) Develop and oversee all evaluation activities and review programs;

(n) Establish and maintain remedies for non-compliance with the Service Responsibilities;

(o) Develop a dispute resolution mechanism to handle any disputes that may arise between an LPCI and the Committee including but not limited to the achievement of the Service Responsibilities;

(p) Establish a communications directorate;

(q) Establish linkages with health information research organizations including, without restriction, the Health Services Utilization and Outcomes Commission;

(r) Recommend longer-term strategies to advance the objectives of primary care improvement in order to support LPCIs and the Initiative; and

(s) Provide input to the budget management and adjustment process set out in Article 8 of the Master Agreement or any other matter as requested or directed by the Secretariat or Master Committee from time to time; and

(t) Prioritize receipt and approval of a Letter of Intent, Business Plan, commencement of LPCIs and timing of funding in respect thereof in accordance with paragraph 13.3.

4.2 The Committee shall, in accordance with the provisions of paragraph 4.3 of the Master Agreement, prepare a Mandate, having due regard for the provisions of paragraph 4.1 above, recommending its terms of reference, roles and responsibilities.

4.3 In the event that the Committee is unable to reach Consensus on any matter properly to be considered by it, that matter shall be forwarded to the Secretariat for consideration.

4.4 Notwithstanding the provisions of paragraph 4.3, any member of the Committee shall be permitted, at any time and from time to time, to require that a matter presently before the Committee be referred to the Secretariat for consideration without the requirement that such matter be brought to a formal vote by the Committee.

ARTICLE 5
PRIMARY CARE INITIATIVE BUDGET

5.1 In order to advance the objectives of the Initiative, the Parties have established a Primary Care Initiative Budget in the amounts, subject to adjustment, initially set out in Schedule "C" to the Master Agreement.

5.2 The amounts set out below will be provided from the Primary Care Initiative Budget to the Association to be used for the Association's Practice Management Program respecting the Initiative, as more particularly described in Article 11 hereof; namely:

(a) in the 2003/04 Fiscal Year, forthwith upon signing this Agreement, the sum of $1,320,000;

(b) For the 2004/05 Fiscal Year, on or about April 1, 2004, the sum of $1,250,000; and

(c) For the 2005/06 Fiscal Year, on or about April 1, 2005, the sum of $1,400,000.

5.3 The Committee shall use the monies in the Primary Care Initiative Budget from time to time, after the payments to the Association contemplated in paragraph 5.2, to support the Initiative and fulfill its responsibilities and obligations as more particularly set out in Article 4 above.

5.4 The Association shall be entitled to carry forward to future fiscal years any unused portion of the funding referred to in paragraph 5.2.

5.5 In the event there is unused or non-accrued funding remaining at the end of the term of this Agreement, the Master Committee shall determine how the remaining funding shall be used. Under no circumstances shall the Master Committee allow the funds to be forfeited.

ARTICLE 6
LETTER OF INTENT

6.1 A Physician and an Authority may submit to the Committee a Letter of Intent to form an LPCI.

6.2 Each Letter of Intent shall be in form and content satisfactory to the Committee and include:

(a) A general description of the LPCI and how the LPCI intends to meet the Service Responsibilities;

(b) A commitment that the Physician and the Authority intend to participate in the LPCI and develop a Business Plan that will meet the requirements prescribed from time to time by the Committee;

(c) Details of the amount of Change Management Funding requested by the applicants and details of the intended use of any such funding allocated by the Committee and a commitment to utilize any such funding allocated to that LPCI only for the intended purposes;

(d) A binding direction to pay, detailing where any Change Management Funding so allocated may be paid; and

(e) such other information as the Committee may from time to time require.

6.3 Each Letter of Intent must be signed by an authorized officer of the Authority and all Physicians intending to participate.

6.4 All Letters of Intent shall be in form and substance satisfactory to the Committee. The Committee shall forthwith review each Letter of Intent and may request further information or clarification it requires before making a decision. The Committee shall approve or reject any Letter of Intent, once in satisfactory form, within fourteen (14) business days of receipt of the last information required.

6.5 The Committee shall notify the applicants within the time set out in paragraph 6.4 if the Letter of Intent has been approved and the date on which it is intended that the initial fifty (50%) of Change Management Funding will flow. If the Letter of Intent has been rejected the reasons for the rejection shall also be stated.

ARTICLE 7
BUSINESS PLAN REQUIREMENTS

7.1 Upon acceptance of the Letter of Intent, the Participating Physicians and the Authority shall be required to develop and agree to a Business Plan for ensuring 24-hour, 7-day-per-week management and delivery of the Service Responsibilities to the intended population.

7.2 The Committee shall develop the requirements for a Business Plan that shall substantially include the following items:

(a) A statement indicating joint agreement between the Participating Physicians and the Authority on the contents of the Business Plan;

(b) The length of the agreement and the provision for continuance;

(c) Renegotiation provisions;

(d) Termination provisions including individual Participating Physician termination;

(e) A dispute resolution process;

(f) The location of the LPCI;

(g) The defined population described in a manner acceptable to the Committee;

(h) The name of each of the Physicians involved;

(i) The roles and responsibilities of the Participating Physicians and the Authority in providing each of the Service Responsibilities;

(j) Identification of all sources of funding flowing to the LPCI, including, without limitation from the Master Physician Budget and Authority budgets;

(k) Specify the allocation of funds between the Participating Physicians and Authority;

(l) An implementation strategy;

(m) A method for approving amendments to the Business Plan, including any specified changes that must be approved by the Committee;

(n) An agreement to adhere to accountability mechanisms developed by the Committee;

(o) Annual financial reporting respecting the operations of the LPCI in form and content satisfactory to the Committee;

(p) The account information which has been established for the purposes of receiving funding; and

(q) Such other matters as may be prescribed by the Committee or which the Participating Physicians and the Authority may consider appropriate and the Committee approves.

7.3 Each Business Plan must be signed by an authorized officer of the Authority and all Participating Physicians.

7.4 Each Business Plan shall be in form and substance satisfactory to the Committee. The Committee shall forthwith review each Business Plan and may request further information or clarification it requires before making a decision. The Committee shall approve or reject any Business Plan, once in satisfactory form, within twenty-one (21) business days of receipt of the last information required.

7.5 The Committee shall authorize payment of the remaining fifty (50%) percent of the allocated Change Management Funding to the LPCI upon approval of the Business Plan.

ARTICLE 8
SERVICE RESPONSIBILITIES

8.1 The Committee shall define the Service Responsibilities, which initially shall include the following, namely:

(a) Those services directly related to the provision of primary care services to the Patient Population:

(i) Basic ambulatory care and follow-up;

(ii) Care of complex problems and follow-up;

(iii) Psychological counselling;

(iv) Screening/chronic disease prevention;

(v) Family planning and pregnancy counselling;

(vi) Well-child care;

(vii) Obstetrical care;

(viii) Palliative care;

(ix) Geriatric care;

(x) Care of chronically ill patients;

(xi) Minor surgery;

(xii) Minor emergency care;

(xiii) Primary in-patient care including hospitals and long-term care institutions;

(xiv) Rehabilitative care;

(xv) Information management; and

(xvi) Population health;

(b) Those services that relate to linkages within or between Primary Health Care and other areas:

(i) 24-hour, 7-day-per-week management of access to appropriate primary care services;

(ii) Access to laboratory and diagnostic imaging; and

(iii) Coordination of:

A. Home care;

B. Emergency room services;

C. Long-term care;

D. Secondary care;

E. Public health; and

(c) Acceptance into the LPCI's Patient Population and provision of the Service Responsibilities to an equitable and agreed upon allocation of unattached Patients.

8.2 The Services Responsibilities will be provided and adhered to by each LPCI and delivered by the Participating Physicians and the Authority according to their agreement as set out in the approved Business Plan.

8.3 Any change to the Service Responsibilities must be approved by the Master Committee and, when so approved, shall be included in all subsequently approved Business Plans. Any LPCI in existence at the time of such a change shall amend its Business Plan to include the changed Service Responsibilities no later than at the next regularly scheduled renewal or any amendment of such Business Plan.

ARTICLE 9
LPCI ENROLMENT AND PAYMENT

9.1 As at the Effective Date, the Annual Per Capita Amount shall be up to fifty ($50) dollars per person subject to allocation and adjustment from time to time, as set out in this Article.

9.2 The Enrolment List of an LPCI may include those Patients who are Formally Enrolled or Informally Enrolled.

9.3 A Patient will initially be eligible to be included on an LPCI's Enrolment List if that Patient has had two or more Encounters with a Participating Physician in the LPCI and included facilities over the previous three-year period.

9.4 The LPCI's Formal Enrolment List will be comprised of all Patients who have signed an Enrolment Agreement with the LPCI and who continue to meet the criteria for remaining Formally Enrolled, namely:

(a) The Patient remains a Resident;

(b) The Patient has not Formally Enrolled with another LPCI; and

(c) Any Patient on a Formal Enrolment List will be automatically excluded from all Informal Enrolment Lists.

9.5 LPCI's that choose to formally enrol Patients must commit to using best efforts to have all their Patients sign an Enrolment Agreement. Patients must be provided the opportunity to terminate an Enrolment Agreement on the conditions specified therein, which termination provisions must be satisfactory to the Committee.

9.6 LPCIs with Formal Enrolment Lists may have a portion of its Patient Population that is Informally Enrolled under the following circumstances:

(a) During the development phase of an LPCI, while the Formal Enrolment List is being built, as determined by the Committee;

(b) Patients who were a long-standing part of a Participating Physician's practice prior to the creation of the LPCI, but who are unwilling to sign an Enrolment Agreement; and

(c) New patients to the LPCI will have an interim period to become Formally Enrolled with the LPCI.

9.7 The LPCI will receive Fifty ($50) dollars per annum for each Patient on the LPCI's Formal Enrolment List.

9.8 Patients entering into an Enrolment Agreement with an LPCI for the first time will remain on the Formal Enrolment List for a minimum of three years, subject always to continuing to meet the eligibility requirements set out in paragraph 9.4 above;

9.9 Following the first three years of Formal Enrolment of a given Patient, and each year thereafter, there will be a retrospective review of the Patient's utilization for the immediately preceding three year period to determine whether or not the LPCI is the Majority Care Provider to that Patient:

(a) If the Patient had two or more Encounters with the LPCI:

(i) and the LPCI is the Majority Care Provider, the Patient will remain on the Formal Enrolment List and the LPCI will continue to receive the Annual Per Capita Amount;

(ii) but if the LPCI is not the Majority Care Provider, the Patient will remain on the Formal Enrolment List and the LPCI will receive a prorated amount of the Annual Per Capita Amount, based on the portion of Encounters received within the LPCI divided by the Patient's total number of Encounters;

(b) If the Patient had less than two Encounters with the LPCI:

(i) but no Encounters outside the LPCI, the Patient will remain on the Formal Enrolment List and the LPCI will receive the Annual Per Capita Amount;

(ii) but had Encounters outside the LPCI, the Patient will remain on the Formal Enrolment List and the LPCI will receive a prorated amount of the Annual Per Capita Amount, based on the portion of Encounters received within the LPCI divided by the Patient's total number of Encounters;

(c) In the circumstances described in sub paragraph 9.9(a)(ii) and 9.9(b)(ii), the LPCI will have one year to demonstrate that it is the Patient's Majority Care Provider. If during that year the LPCI is successful in again becoming the Patient's Majority Care Provider and the Patient signs a new Enrolment Agreement the Patient may (subject always to the eligibility requirements in paragraph 9.4) remain on the Formal Enrolment List for one (1) further year; failing either of which the Patient shall be removed entirely from the LPCI's Enrolment List.

9.10 For the purposes of paragraph 9.9, the Committee may more completely define or refine the meaning of "Encounter", but initially:

(a) An Encounter within an LPCI will include the provision of any of the Service Responsibilities outlined in paragraph 8.1(a) by any of the Participating Physicians in the LPCI, other health care providers within the LPCI or other health care providers outside the LPCI who have made contractual or other written arrangements with the LPCI to deliver some part of the said services; and

(b) An Encounter outside an LPCI will include the provision of any of the Service Responsibilities outlined in paragraph 8.1(a) by other LPCIs or other Physicians.

9.11 For the purposes of paragraph 9.9 the prorated amount will be more fully defined by the Committee, but initially will be determined by the ratio of the number of Encounters for a given Patient provided within the LPCI divided by the aggregate number of Encounters respecting any one or more of the Service Responsibilities received both

inside and outside the LPCI. The prorated amount will be calculated every six months, in conjunction with the semi-annual payment of the Annual Per Capita Amount.

9.12 An LPCI Informal Enrolment List will include all persons who meet the Enrolment criteria identified in paragraph 9.3, who are not on a Formal Enrolment List of any LPCI, and who are not on the Enrolment List of a practice that is funded out of the Insured Services Element under an Alternate Relationship Plan for any primary health care service.

9.13 An LPCI that does not wish to formally enroll Patients may solely maintain an Informal Enrolment List, but payment of the Annual Per Capita Amount will be prorated according to the calculation described in paragraph 9.11.

9.14 The Department shall pay to the LPCI, in the manner identified in the Business Plan, the amount allocated based on the Enrolment List and payment calculations included in this Article 9.

9.15 Payments under this Article shall be made on a prospective basis and paid semi-annually at the time prescribed by the Committee.

ARTICLE 10
CHANGE MANAGEMENT FUNDING

10.1 The Committee will establish Change Management Funding from the Primary Care Initiative Budget, in an amount to be determined, in support of the Committee responsibilities identified in Article 4, including but not limited to:

(a) Day-to-day administration and support of the Initiative;

(b) Funding to support, directly or indirectly, Business Plan development by the Participating Physicians and Authorities;

(c) Funding a communications directorate, in an amount up to $2 million;

(d) Funding through the Department for improvements to information technology and information management systems needed for administration of the primary health care initiatives, in an amount up to $1 million; and

(e) Funding through the Association to support a Practice Management Program, in the amount set out in paragraph 5.2 to be used as set out in Article 11.

10.2 The Change Management Funding referenced above, except that referred to in subsection 10.1(d) will be administered by the Association and be provided by a grant agreement to be entered into with the Department. The grant agreement shall be consistent with the provisions of the Master Agreement and this Agreement, and in a form satisfactory to the Department, acting reasonably.

ARTICLE 11
ALBERTA MEDICAL ASSOCIATION
PRACTICE MANAGEMENT PROGRAM

11.1 The Association shall be provided funding as defined in paragraph 5.2 to carry out the following deliverables in a manner reasonably determined by the Association including:

(a) Primary Care Initiative Workshop

(i) The Association shall host a workshop designed to build support for the Initiative and to begin development of Physician and Authority leaders; and

(ii) The Association shall invite participants that will represent Physician practices and Authorities from across Alberta.

(b) Support of Physician Practices

(i) The Association, in consultation with the stakeholders the Association deems necessary, will provide assistance to individual Physician practices that are interested in developing a Business Plan with an Authority. In performing this role, the Association will work closely with the Committee to ensure integration with the Committee's change management program;

(ii) The Association will assist Participating Physicians by providing support in respect of issues such as group formation, practice governance, relationship issues, taxation, financial projections, liability issues, and any other issues the Association deems necessary;

(iii) The Association's Practice Management Program is intended to support primary care Physicians and specialists on a practice/group specific basis and is not intended to provide those services more appropriately dealt with by the Committee including but not limited to those responsibilities referred to in Article 10; and

(iv) To better represent Physicians in Alberta, the Association shall establish a Calgary office to support and assist primary health care and specialist care initiatives.

11.2 The Association shall, no later than thirty (30) days after the end of each quarter of each Fiscal Year during the term of this Agreement, provide the Department with internal financial statements respecting the Practice Management Program, prepared in accordance with Generally Accepted Accounting Principles, and certified to be complete and accurate in all respects by the Assistant Executive Director (Corporate Affairs) of the Association.

ARTICLE 12
SPECIALIST LINKAGES TO THE PRIMARY HEALTH CARE INITATIVE

12.1 The Parties shall allocate ten million ($10,000,000) dollars from the Primary Care Initiative Budget to establish mechanisms and incentives to recognize the value-added services in specialist linkages to the primary care initiative.

ARTICLE 13
PRIORITIZATION WITHIN THE INITIATIVE

13.1 The Parties intend to have LPCIs broadly available to Albertans, but recognize that this will take time to develop and that some staging of the development and creation of LPCIs will be required.

13.2 From the date the Master Agreement is signed through and until June 30, 2004 the Parties anticipate that the Committee will only be able to approve up to twelve (12) Letters of Intent from across the Province. It is anticipated that these potential LPCIs will assist the Committee in developing the experience and expertise required to expedite a more general rollout of LPCIs across the Province. The process for selecting these projects will be the responsibility of the Committee.

13.3 The Committee shall establish and communicate to Physicians and Authorities any criteria for receiving, reviewing and approving Business Plans and for implementing same, which will include consideration of the following:

(a) Size of the LPCIs defined population in relation to the characteristics and size of the general population of the region;

(b) Commitment of the local Physicians and Authority to establish and maintain the LPCI; and

(c) Ability of the local Physicians and Authority to clearly define and establish within the Business Plan the population they intend to serve.

ARTICLE 14
OTHER RELATED MATTERS

14.1 Nothing in this Agreement shall limit:

(a) a Physician or an Authority from accessing funding from the Primary Care Initiative Element based on a Physician's choice of remuneration from the Insured Services Element; or

(b) a Physician from accessing any other funding source.

MASTER AGREEMENT REGARDING THE TRI-LATERAL RELATIONSHIP AND BUDGET MANAGEMENT PROCESS FOR STRATEGIC PHYSICIAN AGREEMENTS

MADE EFFECTIVE APRIL 1, 2003

SCHEDULE "H"

PHYSICIAN ON CALL PROGRAMS AGREEMENT

The text of Schedule "H" commences on the immediately following page.

PHYSICIAN ON-CALL PROGRAMS AGREEMENT MADE EFFECTIVE THE 1ST DAY OF APRIL, 2003

AMONGST:

HER MAJESTY THE QUEEN
IN RIGHT OF ALBERTA
as represented by the
MINISTER OF HEALTH AND WELLNESS
(the "Department")

And

THE ALBERTA MEDICAL ASSOCIATION
(C.M.A. Alberta Division)
(the "Association")

And

THOSE REGIONAL HEALTH AUTHORITIES
IDENTIFIED IN SCHEDULE "A"
ATTACHED TO THE MASTER AGREEMENT
(the "Authorities")

RECITALS:

A. The Parties have entered into a Master Agreement regarding the Tri-Lateral Relationship and Budget Management Process for Strategic Agreements (the "Master Agreement") dated for reference the 1st day of April, 2003;

B. The Master Agreement contemplates that the Parties will enter into this Strategic Agreement respecting the Physician On-Call Programs Budget;

C. The provision of emergency on call services in Alberta poses significant lifestyle and economic challenges for Physicians providing this important service for the Authorities; and

D. The recognition of and compensation for the provision of emergency on call services is a significant measure to enhance the provision of patient care and the recruitment and retention of Physicians to Alberta.

THEREFORE, the Parties promise and agree with each other as follows:

ARTICLE 1.
DEFINITIONS AND INTERPRETATION

1.1 In this Agreement terms with initial capitals and defined in Schedule "J" to the Master Agreement have the meanings ascribed to such terms therein and the following

terms have the meanings set out herein, unless there is something in the subject matter or context inconsistent therewith:

(a) **"Agreement"** means this Physician On Call Programs Agreement and any appendices annexed hereto;

(b) **"Committee"** means the Physician On Call Programs Committee formed pursuant to paragraph 4.1(d) of the Master Agreement with responsibility for the management and administration of this Agreement and the Physician On Call Programs Budget as more particularly set out in Schedule "C" to the Master Agreement;

(c) "**Programs**" or "**On Call Programs**" mean those programs relating to the provision of on call services by Physicians as determined from time to time by the Master Committee on recommendation of the Committee, and initially means the Specialist On Call Program ("SOC") and the Provincial Rural On Call Program ("ROC") as more particularly described and set out in Appendix "A" and "B" annexed hereto.

1.2 The interpretative provisions set out in Article 13 (except the provisions of paragraph 13.8) and the general provisions set out in Article 14 (except the provisions of paragraph 14.8) of the Master Agreement are incorporated into and form part of this Agreement.

1.3 The recitals and the following appendices are incorporated into and form part of this Agreement:

Appendix "A" Management of Physician On Call Programs; and

Appendix "B" Specialist On Call Payment Level Factors

ARTICLE 2.
TERM

2.1 The term of this Agreement shall commence on the Effective Date and shall, notwithstanding any notice to reopen negotiations served pursuant to paragraph 11.2 of the Master Agreement, remain in full force and effect only until twelve (12) o'clock midnight March 31, 2011.

ARTICLE 3.
PHYSICIAN ON CALL PROGRAMS COMMITTEE

3.1 The Committee shall deal with all matters related to the expenditure of monies comprising the Physician On Call Programs Budget, or any Element thereof, all in accordance with the provisions of Appendix "A" and "B" attached hereto, including but not limited to:

(a) Setting Authority reporting requirements;

(b) Developing accountability and evaluation criteria for eligible SOC programs;

(c) Reviewing and responding to information acquired through evaluation of the Programs, including, making recommendations regarding any required modifications to the Programs;

(d) Acting as the Appeals Committee respecting SOC level and full-time equivalent disputes;

(e) Recommending the inclusion of new programs and facilities eligible for Program funding;

(f) Recommending annual rates after the review of new programs and Program appeals;

(g) Recommending the use of any surplus Program funds held by the Authorities at the end of each 6 months for each Fiscal Year; or

(h) Provide input into the Budget Management and Adjustment Process set out in Article 8 of the Master Agreement or any other matter as requested or directed by the Secretariat or the Master Committee from time to time.

3.2 In the event that the Committee is unable to reach Consensus on any matter properly to be considered by it, that matter shall be forwarded to the Secretariat for consideration.

3.3 Notwithstanding the provisions of paragraph 3.2, any member of the Committee shall be permitted, at any time and from time to time, to require that a matter presently before the Committee be referred to the Secretariat for consideration without the requirement that such matter be brought to a formal vote by the Committee.

3.4 The Committee shall, in accordance with the provisions of paragraph 4.3 of the Master Agreement, prepare a Mandate, having due regard for the provisions of paragraph 3.1 above, recommending its terms of reference, roles and responsibilities.

ARTICLE 4
PROGRAM OBJECTIVES

4.1 Objectives of the On Call Programs are as follows:

(a) General:

(i) to enhance high quality, effective and efficient patient care delivery;

(ii) to achieve equity in terms of remuneration for On Call Programs;

(iii) to minimize competition among Authorities for Physician resources;

(iv) to establish Physician On Call Program rules, parameters and guidelines that are transparent, objective and equitable across all eligible On Call Programs;

(v) to provide remuneration for covering regionally mandated On Call Programs;

(vi) to identify all Parties' accountabilities and responsibilities with regard to On Call Programs; and

(vii) to ensure the appropriate relationship between the Specialist On-Call Program and the Rural On-Call Program with other Programs.

(b) Specialist On-Call:

(i) to remunerate Physicians for providing eligible specialist On Call Programs and other approved programs.

(c) Rural On-Call:

(i) to recognize and compensate Physicians for the unique lifestyle and economic circumstances of providing emergency on call in rural areas and to provide an incentive to increase the number of Physicians who provide rural emergency on call services; and

(ii) to ensure that Albertans living in rural and remote locations of the province receive comprehensive and continuous emergency on call services.

ARTICLE 5
PHYSICIAN ON-CALL PROGRAMS BUDGET

5.1 The Parties have agreed that, subject to adjustment, if any, the Physician On Call Programs Budget will, at the start of any Fiscal Year, initially be those amounts set out in Schedule "C" and comprising a portion of the Master Physician Budget.

5.2 The Committee will, in accordance with directions received, from time to time, from the Secretariat or the Master Committee as the case might be, monitor, manage and report on the Physician On Call Programs Budget.

5.3 The Committee will report to the Secretariat on such other date to be specified by the Secretariat, of each Fiscal Year respecting, without limitation:

(a) The projected surplus or deficit in Program funding for that Fiscal Year;

(b) The projected surplus or deficit in Program funding cumulative from the Effective Date;

(c) Authority's financial reporting;

(d) Number of On Call Programs, by type, by specialty, by Authority;

(e) Outcomes of Appeals Process;

(f) Projections of future On Call Program/facility demand;

(g) Recommendations with regard to adjustments to Program funding to recognize changes in On Call Programs; and

(h) Other reports as requested by the Secretariat or the Master Committee from time to time.

5.4 Program rates are effective April 1 of each Fiscal Year and will be adjusted within available funding for each Fiscal Year. The following is the priority for determining Program rates:

(a) The annual list of eligible Programs and eligible facilities based upon:

(i) the outcome of SOC appeals as determined by the Committee;

(ii) adjustments (additions and deletions) to the list of eligible SOC Programs submitted by the Authorities and approved by the Committee; and

(iii) adjustments (additions and deletions) to the list of eligible ROC facilities submitted by the Authorities and approved by the Committee.

(b) The Committee shall establish a reserve, in an amount determined by the Committee and reasonably required for Program needs, at the beginning of each Fiscal Year that will allow for the addition of new programs during the course of a Fiscal Year;

(c) Should there be unused funds after the adjustments referred to in sub paragraphs (a) and (b) above then, with approval of the Master Committee, the following increases shall be implemented in the order of priority set out, namely:

(i) Increase all SOC levels by an amount up to 4.6%, so that the annual remuneration for Level II SOC Programs is equal to the annual remuneration for the ROC Programs;

(ii) Increase all Program rates by an amount up to the percentage increase contemplated for that Fiscal year and set out in paragraph 8.4 of the Master Agreement; and

(iii) Should there be unused funds after the adjustments referred to in sub paragraphs (i) and (ii) immediately above, the Committee shall report this to the Secretariat and Master Committee and seek direction regarding the use of any remaining surplus funds.

Appendix A

To The Physician On Call Programs Agreement
Made Effective the 1st day of April, 2003

MANAGEMENT OF PHYSICIAN ON CALL PROGRAMS

Compliance Principles

Authorities receiving Program funding and all Physicians participating in the Program shall comply with Program parameters, as determined from time to time by the Committee. The Department, upon recommendation from the Committee, may withhold Program funding to Authorities that fail to comply with such parameters and require such Authorities to restore any funds paid in contravention of Program parameters.

Authorities shall withhold Program remuneration from Physicians who fail to comply with Program parameters. Physicians who fail to provide Program services shall, upon recommendation of the Committee, be required to repay to the Authority any or all remuneration received.

Provincial Specialist On-Call Program

1. **Program Design**

(a) Definition of On Call

Specialist Physicians are available, where the Authority requires, to see new patients on other services and to provide emergency specialty care in, but not limited to, the emergency department in an acute care facility, as part of a defined call schedule.

(b) Purpose of Remuneration

To remunerate specialist Physicians for the provision of 'eligible' on call services to the Authorities. Remuneration will not be provided to specialist Physicians to be 'available' for their own patients or patients of their on call associates.

(c) Eligible Provincial SOC Services and Programs

All SOC Programs involving specialist Physicians and rural general practitioners with special skills providing on call services within an Authority at the start of each Fiscal Year or identified from time to time in the process of identifying new Programs.

(d) Rural General Practitioners with Special Skills

All rural specialty programs involving suitably qualified general practitioners providing any of the following specialty services within their community:

- GP Anesthesia
- GP General Surgery
- GP Obstetrics

The Committee may consult with the Rural Action Plan Coordinating Committee (RPAPCC) on matters concerning rural Physicians.

(e) New and Specialized Programs

Application by Authorities for new SOC Programs and new specialized On Call Programs, e.g. palliative care, that may include family Physicians, may be added to the list of eligible Programs.

(f) Multiple-Level Program

The Provincial SOC Program is designed to remunerate specialist Physicians who participate in eligible SOC Programs within Authorities using the ratings determined by the Authorities. There are three levels of payment intended to recognize Physician availability and burden during the provision of SOC services. Program levels shall be determined by Authorities but may be appealed to the Committee.

2. **Service Requirements**

The Provincial SOC Program is not intended to compensate Physicians for coverage of their own patients or for the patients of their on call associates. This Program is intended to remunerate Physicians for their availability to provide specialist consultation to new patients on other services and to provide emergency specialty care in, but not limited to, the emergency department in an acute care facility as part of a defined call schedule. SOC Programs that are eligible for remuneration in Alberta must meet the following conditions:

(a) sanctioned by the site or regional leaders;

(b) inventoried and submitted for review by the Authority to the Committee, and

(c) meet the eligibility criteria.

While on call for a specialty or service, Physicians must respond for consultation requests (telephone or direct examination). The Authority will define acceptable timelines. A Physician scheduled to be on call who will not be able to respond within acceptable timelines shall make arrangements with a colleague to cover them during this time.

Call rosters should be designed to enable Physicians to provide safe and timely patient care. The on call roster should be made available to all departments in the site or Authority that may need to contact the Physician on call.

A Physician who provides on call services to two different Programs for the same period, will be paid (once) through the Program that remunerates at the higher rate. If the remuneration for each Program in which a Physician participates is the same, the Authorities will choose the Program to debit. If a Physician participates in Programs in more than one Authority, the Authorities shall determine themselves which regional Program the Physician will be deemed to participate in. Any disagreements between Authorities shall be referred to the Committee for determination.

Provincial Rural On-Call Program

1. **Program Design**

(a) Definition of On Call

Rural Physicians available to provide emergency on call services provided in eligible facilities.

(b) Purpose of Remuneration

To remunerate rural Physicians for the provision of emergency on call services to eligible facilities for the Authorities.

Remuneration will be paid in addition to income earned by a Physician during an on call shift, either through fee-for-service or alternative payment arrangements without affecting the fee schedule or governing rules.

(c) Eligible Provincial ROC Services and Programs

The following criteria are used to establish the list of eligible facilities under the ROC:

- acute care facilities, which offer to the general public emergency on call coverage 24 hours per day, 365 days per year;
- where the emergency department is not staffed full-time by Physicians practicing emergency medicine;
- where there are 25,000 or fewer unscheduled visits annually to the emergency department; and
- other facilities approved on a case by case basis by the Master Committee on recommendation or report of the Committee.

2. **Service Requirements**

The Provincial ROC Program is intended to compensate Physicians for coverage of emergency on call for eligible facilities during an on call shift. Funding shall be provided at a fixed hourly rate to cover the following emergency on call hours:

(a) All hours with the exception of the hours of Monday to Friday, 8 a.m. to 5 p.m.;

(b) Where a statutory holiday falls on a weekday (Monday to Friday), the hours from 8 a.m. to 5 p.m. are included;

For the ROC to provide meaningful lifestyle improvement, where possible, a Physician should not be on call more than one day in four, as long as this does not compromise the objective of providing full on call coverage.

To avoid excessive on call provision by individual Physicians, the Chiefs of Staff of the Authorities shall review the on call schedules with the Physicians providing this service in their Authority.

The on call funding per facility is to be shared among the Physicians who provide on call services at an eligible facility, based on the number of hours of on call service provided by each physician. Where two or more Physicians share on call hours at the same eligible facility, only one payment covering the hours provided at the facility will be made.

Laboratories

Effective April 1, 2003, laboratory Physician Programs shall be counted by the Authorities and are eligible for inclusion in the SOC Program.

Oncology Programs

Effective April 1, 2003, oncology Physician On Call Programs operated by either the Authorities or the Alberta Cancer Board shall be counted by the Authorities and are eligible for inclusion in the SOC Program.

Evaluation Requirements

(a) Authority Reporting/Evaluation Requirements

The Authorities will provide a semi-annual summary of Program financial status information for each Fiscal Year of this Agreement.

(b) On Call Programs Committee Evaluation Responsibilities

The Committee will review and respond to an Evaluation Report (prepared by the Department) that includes the On Call Programs Budget Statement and a compilation of "Issues" submitted by the Authorities (or Association) as part of the reporting requirements.

The Committee shall provide its Program evaluation report to the Secretariat on an annual basis or at such other times as the Secretariat or the Master Committee might request.

Appeals

(a) Appeals

The Committee will decide appeals from Physician groups who wish to challenge Program levels or FTE designations to reflect the current delivery of On Call services. Issues concerning Program design may not be appealed.

The final date for submission of SOC Appeals is January 31 of each Fiscal Year, or such other date as the Committee determines, and will be considered by the Appeals Committee for changes commencing at the beginning (April 1) of the following Fiscal Year.

(b) Process

(i) All appeals regarding level designations/fractional designations will first be referred for review to the appropriate Physician leader of the specialty service in question. The Physician leader, will forward the appeal to the designated medical leader appointed by the Authority for review. If this individual agrees, he or she shall send a letter of support to the Committee for information;

(ii) If the matter cannot be resolved at the local level, the Authority shall send it to the Committee for determination;

(iii) Supporting documentation required to be provided to the Committee by the Physician leader or medical leader appointed by the Authority shall:

A. identify each factor being challenged

B. include data and information that would support the appeal; and

C. reflect a minimum 30-day retrospective period of on call activities reflecting all components used to determine the level as outlined in Appendix B.

The Committee will review the written appeal and the supporting documents submitted by the medical leader appointed by Authority. If the Committee requires additional information, it will have thirty (30) days to request this information.

1. With fifteen (15) days of receiving all requested information, the Appeals Committee will review the written appeal and relevant information.
2. Any decisions resulting from an appeal process, whether for approval or rejection will be communicated to the medical leader making the application within thirty (30) days following the date of the Appeals Committee review.
3. Final rates for each Fiscal Year will be determined upon the completion of the appeals process. There will be no retroactive application of such decisions to the previous Fiscal Year.

(c) Records Maintained by Committee

The Committee will act as an office of record for written appeals and reviews brought forward to the Committee.

(d) Operation

(i) Association Physician representatives are to excuse themselves from hearing appeals/reviews from their own specialty/subspecialty or their own Authority. Those who are excused are to be replaced by an alternate appointed by the Association.

(ii) Authority representatives are to excuse themselves from hearing appeals/reviews from their own Authority. Those who are excused are to be replaced by an alternate appointed by the Authority.

Process to Add/Delete Programs or Facilities

(a) Program Deletion

Programs will be deemed to have been deleted from the Program if they no longer meet the eligibility requirements for the Program.

(b) Addition of Programs or Facilities

Authorities may request the addition of new programs or facilities to the Program. Requests must be in writing and must contain evidence that the requested program meets the eligibility requirements for the SOC or ROC Programs.

(c) Process

(i) Requests for new programs that are received by January 31 of each year, or such other date as the Committee determines, will be taken into consideration, along with the appeals, when the Program rates are set for that Fiscal Year. If eligible On Call Programs commence at other times during the year, the Committee will review the requested addition within 30 days of the request being presented to the Committee. The Committee may request additional information from the Authority making the application;

(ii) Within 30 days of receiving all the necessary information, the Committee's decision will be communicated to the Authority and the payment will be effective on the date the On Call Program starts [or started] within that current Fiscal Year.

(d) Authority

Applications for new programs will not result in retroactive payments to the previous year.

Appendix B

To The Physician On Call Programs Agreement
Made Effective the 1st day of April, 2003

Specialist On-Call Payment Level Factors

These factors are intended indicate the Level that will be used to assess payment for on call services. The points description applies to general occurrences for the period of call, week or year.

RESPONSIVENESS	
How urgently the specialist must stop activities at the time of the call and proceed to the hospital as an appropriate response to the call.	
Points	Description
1	Low, within the period of your call
5	Moderate, within 2 hours
10	High, within 30 minutes
15	Very High, required to be on–site

PROBABILITY OF CALL	
The likelihood of receiving urgent phone calls and follow-up calls concerning patient wellbeing.	
Points	Description
1	Low, 2 or less calls per call period
4	Moderate, 3 to 6 calls per period of call
8	High, 7 and greater calls per period of call

MULTIPLE-SITE COVERAGE	
The specialist physician, or program team members, are required to be available to respond to on call notification from more than one hospital site, and must attend. (Not where a single site may receive patients from multiple sites)	
Points	Description
1	Respond and attend to only one site
3	Respond and attend to multiple sites 1 to 3 days a week
5	Respond and attend to multiple sites 4 to 7 days a week

CLINICAL SUPPORT

Considers if clinical support is necessary and available to the specialist:

- There are no points assigned for technical call schedules where the physician must attend to provide the technical service and there is no ongoing care of the patient. Examples are anesthesia and radiology, or endoscopy and cardiac catheterization where these are separate call schedules.

This includes clinical or other alternate care provider support that materially alters call work load:

• Clinical support includes residents and support provided through the acute care coverage program that is funded by AHW and provides regions money to hire hospitalists, nurse practitioners, etc. to assist specialists in providing ward care to their patients.	
Points	Description
0	Clinical support not applicable
2	Clinical support available more than 3 months a year
5	Clinical support is available 3 months or less a year

Program Levels and Payment Rates:

The sum of the points determines the program level of annual payment rate.

Level 1	Weighting __
22 – 33 points	

Level 2	Weighting __
12 – 21 points	

Level 3	Weighting __
1 - 11 points	

All rural specialty programs involving suitably qualified general practitioners providing any of the following specialty services within their community (consistent with adopted on call definition):

- GP Anesthesia
- GP General Surgery
- GP Obstetrics

MASTER AGREEMENT REGARDING THE TRI-LATERAL RELATIONSHIP AND BUDGET MANAGEMENT PROCESS FOR STRATEGIC PHYSICIAN AGREEMENTS

MADE EFFECTIVE APRIL 1, 2003

SCHEDULE "I"

EXISTING PHYSICIAN RECRUITMENT PLANS

(referenced in paragraph 8.10(b)(i) of the Master Agreement)

1) Calgary Paediatric

Made effective the 1st day of July, 2002 and made between the Province, as represented by the Minister; the Association; the Calgary Health Region; The Governors of the University of Calgary and a scheduled list of persons named in Schedule "A".

2) Edmonton Paediatric

Made effective the 1st day of November, 2002 and made between the Province, as represented by the Minister; the Association; Capital Health Authority; The Governors of the University of Alberta and a scheduled list of persons named in Schedule "A".

3) U of A Department of Medicine

Dated for Reference the 1st day of April, 2002 and made between the Province, as represented by the Minister; the Association and a scheduled list of persons named in Schedule "A", as represented by the Chair, Department of Medicine, Faculty of Medicine and Dentistry, at the University of Alberta.

4) Neurosurgery

Made effective January 1, 2001 and made between the Province, as represented by the Minister; the Association; Capital Health Authority; Calgary Health Region; The Governors of the University of Calgary, as represented by the Dean of the Faculty of Medicine; The Governors of the University of Alberta, as represented by the Dean of the Faculty of Medicine and Dentistry and a scheduled list of persons named in Schedule "A".

Note: The Alternate Funding Plans identified in items 1 and 2 above do not contain explicit Physician recruitment plans. These agreements contain projected budgets and average Physician payment rates from which the intended Physician recruitment numbers may be inferred.

MASTER AGREEMENT REGARDING THE TRI-LATERAL RELATIONSHIP AND BUDGET MANAGEMENT PROCESS FOR STRATEGIC PHYSICIAN AGREEMENTS

MADE EFFECTIVE APRIL 1, 2003

SCHEDULE "J"

DEFINITIONS

In this Master Agreement and any Strategic Physician Agreement entered into, or Mandate approved, under the terms hereof the following terms have the meanings set out herein, unless there is something in the subject matter of context inconsistent therewith, namely:

(a) "**Act**" means the *Alberta Health Care Insurance Act*, being Chapter A-20 of the Revised Statutes of Alberta, 2000;

(b) "**Actual Expenditure**" means the amount actually paid in respect of a Fiscal Year to or on behalf of Physicians from Master Physician Budget or any Element thereof;

(c) "**Acute Care Coverage Program**" means a program existing within an Authority as at the Effective Date to compensate health care providers to address regional acute care needs, excluding on-call payments to Physicians;

(d) "**AFP**" means a program existing as at the Effective Date to compensate one or more Physicians for the provision of a range of services that includes Insured Services and may include, as one component of such program, an APP;

(e) "**Alternate Relationship Plan**" means an agreement to deliver services, including Insured Services, pursuant to which Physicians are compensated in a manner other than through fee for service and includes an AFP or APP;

(f) "**APP**" means a program existing as at the Effective Date to compensate one or more Physicians for the provision of Insured Services other than through fee for service payments for the provision of such services;

(g) **"Association**" means The Alberta Medical Association (C.M.A. Alberta Division), a society formed under the *Societies Act* being Chapter S-14 of the Revised Statutes of Alberta, 2000;

(h) "**Authorities**" means collectively those regional health authorities formed under the *Regional Health Authorities Act* being Chapter R-10 of the

Revised Statutes of Alberta, 2000 and "**Authority**" means any one of such Authorities;

(i) "**Benefit Element**" means that portion of the Physician Services Budget to the maximum amount agreed to by the Parties to be utilized in a Fiscal Year for Benefit Plans;

(j) "**Benefit Plans**" means those benefit plans the objectives of which are more particularly described in Appendix "A" to the Physician Services Agreement;

(k) "**Benefit Surplus**" means, unless otherwise determined by Consensus of the Master Committee, the aggregate of the following surplus amounts reasonably determined by the Association as required to:

(i) fund future claims under the Continuing Medical Education program in accordance with the terms thereof; and

(ii) operate the Benefit Plans from year to year, which surplus amount shall not exceed the sum of $1,000,000.

As at March 31, 2003 the current surplus in respect of sub paragraph (i) above was $6,871,976 (book and market value) and the current surplus in respect of sub paragraph (ii) above was $4,312,472 (book value), $3,004,259 (market value). The difference between the current surplus in respect of sub paragraph (ii) and the sum of $1,000,000 shall not be considered as surplus but rather shall be utilized by the Association:

(iii) with respect to the sum of $382,168, to supplement funding for the activities of the Best Practices Initiative Program; and

(iv) with respect to the balance of the said surplus to maintain or enhance the Benefit Plans, including the Specialist Locum Program, the Physician and Family Support Program and implement a Parental Leave Program;

(l) "**Consensus**" means the unanimous agreement of the individual members of the Master Committee, the Secretariat or an SPA Committee as the case might be;

(m) "**De-Insure**" or "**De-Insurance**" means, in respect of an Insured Service, the decision of the Minister that such Insured Service is no longer an Insured Service and no longer payable under the Plan;

(n) "**Department**" means the department designated under the *Government Organization Act* to deal with health care matters for Albertans, and initially means the Department of Health and Wellness;

(o) "**Effective Date**" means, in respect of this Master Agreement or an initial Strategic Physician Agreement,12:01 a.m. April 1, 2003;

(p) "**Element**" means, when used in reference to the Master Physician Budget, an allocation into a sub budget to be managed according to a Strategic Physician Agreement or an identified sum of money or expenditure category; but does not include specific rates in the Schedule or a Provincial Payment Rate;

(q) "**Fiscal Year**" means a period of time occurring during the term of this Master Agreement commencing April 1 on any calendar year and ending March 31 in the next ensuing calendar year;

(r) "**Health Care Delivery System**" means the delivery of quality health care services to Albertans through a delivery system which is accessible, predictable, integrated, sustainable, adaptable, accountable, efficient and effective;

(s) "**Insured Services**" means an insured service, as defined in the Act, provided by a Physician to a Resident;

(t) "**Insured Services Element**" means that portion of the Physician Services Budget to the maximum amount agreed to by the Parties to be utilized in a Fiscal Year for the provision of Insured Services, whether through fee for service payments in accordance with the Schedule or an Alternate Relationship Plan;

(u) "**Interpretation Fee**" means a payment made to a Physician from an Authority budget for the interpretation of non-invasive diagnostic tests performed within a hospital operated by that Authority;

(v) "**Legacy APP**" means those Alternate Payment Plans more particularly identified in Schedule "D" of the Master Agreement, all of which were transferred by assignment to the respective Authority in or about October, 1997;

(w) "**Mandate**" means the mandate of a Strategic Physician Committee created pursuant to paragraph 4.3 of the Master Agreement and approved by the Master Committee;

(x) "**Master Agreement**" means this agreement regarding the Tri-lateral Relationship and Budget Management Process for Strategic Physician Agreements dated for reference the 1st day of April, 2003 and all Schedules attached hereto or Strategic Physician Agreements resulting here from, all as might be amended from time to time in accordance with the provisions hereof;

(y) "**Master Committee**" means the Tri-lateral Relationship and Budget Management Process Master Committee formed pursuant to paragraph 3.1(a) of the Master Agreement;

(z) "**Master Physician Budget**" means the aggregate annual amount, initially, set out in Schedule "C" of the Master Agreement to fund the

programs, benefits or services provided under the Strategic Physician Agreements;

(aa) "**Minister**" means the member of Executive Council charged with the administration of the Act from time to time, and initially means the Minister of Health and Wellness, and any person authorized to act in his behalf;

(bb) "**Over Expenditure**" or "**Over Expended"** means the amount, if any, in respect of a Fiscal Year by which an Actual Expenditure exceeds the amount of the Master Physician Budget, or any Element thereof;

(cc) "**Party**" means any one of the Department, the Association or the Authorities and "**Parties**" means all of the foregoing;

(dd) "**Physician**" means, with reference to medical services provided in Alberta to a Resident, a person who is registered as a medical practitioner or an osteopathic practitioner under the *Medical Profession Act*, being Chapter M-11 of the Revised Statutes of Alberta, 2000;

(ee) "**Physician Agreement**" means any agreement, between one or more Authorities and a Physician, who performs a clinical practice or provides Insured Services, by which the Authority intends to pay money or provide a benefit to that Physician;

(ff) "**Plan**" means the Alberta Health Care Insurance Plan as referred to in the Act;

(gg) "**Prior Agreements**" means the agreements between Alberta and the Association identified in Schedule "B" attached hereto;

(hh) **"Provincial Payment Rate**" means the contribution from the Insured Services Element agreed to by the Physician Services Committee, the Secretariat or the Master Committee as the case might be to compensate Physicians for services, including Insured Services, to be provided under an Alternate Relationship Plan;

(ii) "**Regulation**" means the Medical Benefits Regulation (Alta. Reg. 173/93) made pursuant to the Act;

(jj) "**Relationship"** means that new tri-lateral relationship created amongst the parties and described herein;

(kk) "**Resident**" means a resident as defined in the Act;

(ll) "**Schedule**" means the Schedule of Medical Benefits used in the operation of the Plan and prepared and published by the Department and approved by the Minister in accordance with the Act;

(mm) "**Secretariat**" means that Tri-lateral Relationship and Budget Management Process Secretariat formed pursuant to paragraph 3.1(b) of the Master Agreement;

(nn) "**SPA Committee**" means a committee formed pursuant to Article 4 of the Master Agreement to manage and oversee the operation of a Strategic Physician Agreement; and

(oo) "**Strategic Physician Agreement**" means an agreement entered into pursuant to the Master Agreement, and initially means those agreements identified in sub paragraphs 5.1(a) through (d) of the Master Agreement.

MASTER AGREEMENT REGARDING THE TRI-LATERAL RELATIONSHIP AND BUDGET MANAGEMENT PROCESS FOR STRATEGIC PHYSICIAN AGREEMENTS

MADE EFFECTIVE APRIL 1, 2003

SCHEDULE "K"

ADDRESSES FOR NOTICE PURSUANT TO PARAGRAPH 13.4

if to **The Department**

Alberta Health and Wellness
10025 Jasper Avenue
P.O. Box 1360 Station Main
Edmonton, Alberta
T5J 2N3

Attn: Deputy Minister

Facsimile Number: (780) - 427-1016

and if to **The Association**
The Alberta Medical Association
(C.M.A. Alberta House)
12230 - 106th Avenue N.W.
Edmonton, Alberta
T5N 3Z1

Attn: Executive Director

Facsimile Number: (780) - 482-5445

and if to **Aspen Regional Health Authority**
Regional Office
Provincial Building
10003 – 100 Street
Westlock, Alberta
T7P 2E8

Attn: Chief Executive Officer

Facsimile Number: (780) – 349-4879

Calgary Health Region
10101 Southport Road S.W.
Calgary, Alberta
T2W 3N2

Attn: Chief Executive Officer

Facsimile Number: (403) – 943-1108

Capital Health
1J2 Walter Mackenzie Centre
8440 – 112 Street
Edmonton, Alberta
T6G 2B7

Attn: Chief Executive Officer

Facsimile Number: (780) – 407-7481

Chinook Regional Health Authority
960 – 19 Street South
Lethbridge, Alberta
T1J 1W5

Attn: Chief Executive Officer

Facsimile Number: (403) – 382-6011

David Thompson Regional Health Authority
602, 4920 – 51 Street
Red Deer, Alberta
T4N 6K8

Attn: Chief Executive Officer

Facsimile Number: (403) – 341-8632

East Central Health
4703 – 53 Street
Camrose, Alberta
T4V 1Y8

Attn: Chief Executive Officer

Facsimile Number: (780) – 672-5023

Northern Lights Health Region
7 Hospital Street
Fort McMurray, Alberta
T9H 1P2

Attn: Chief Executive Officer

Facsimile Number: (780) – 791-6029

Palliser Health Region
666 – 5th Street S.W.
Medicine Hat, Alberta
T1A 4H6

Attn: Chief Executive Officer

Facsimile Number: (403) – 529-8998

Peace Country Health
2101, 10320 – 99 Street
Provincial Building
Grande Prairie, Alberta
T8V 6J4

Attn: Chief Executive Officer

Facsimile Number: (780) – 538-5455